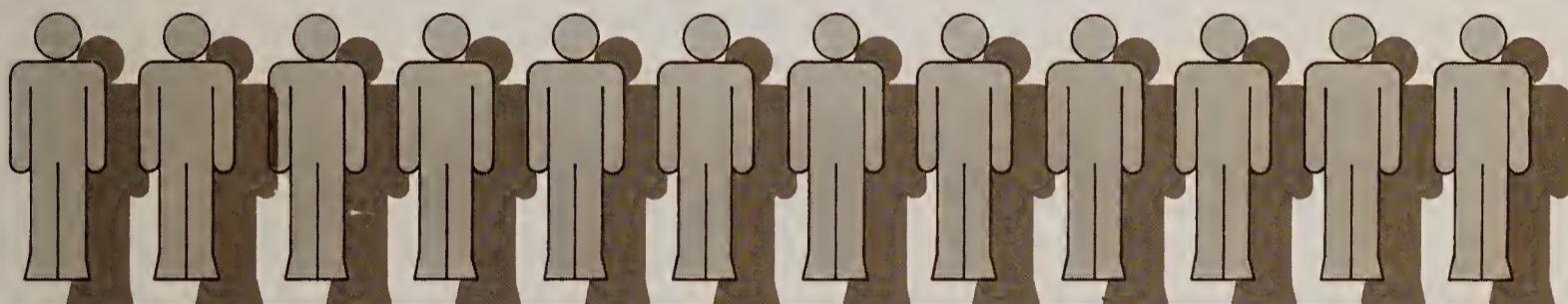
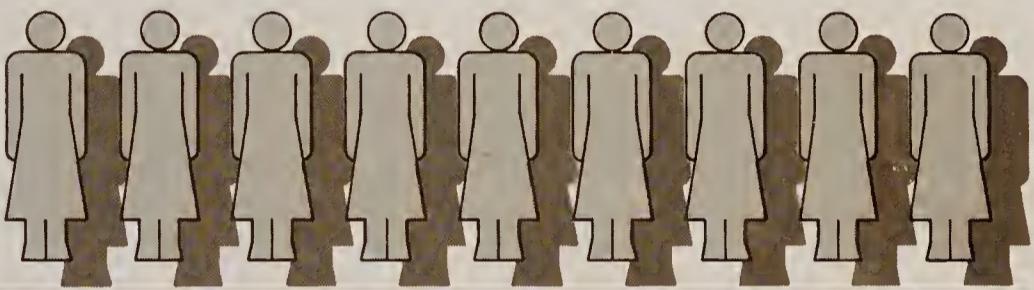
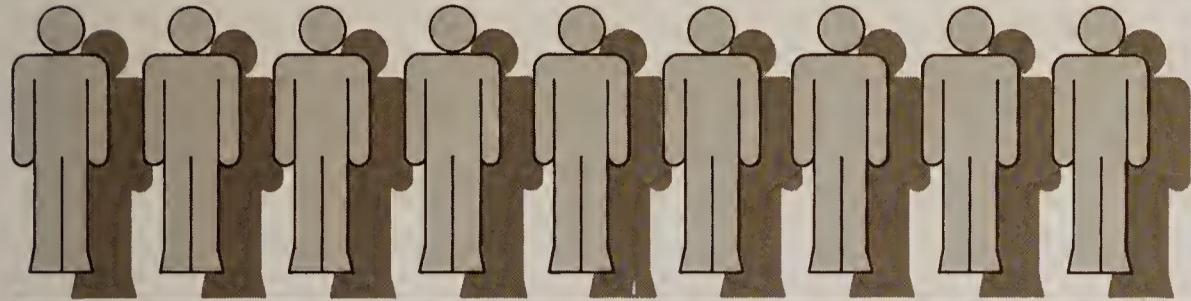


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# **A Profile of Mexican American Health: Data from the Hispanic Health and Nutrition Examination Survey 1982-84**

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Arlington, Texas**

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**September, 1987**



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## **Foreword**

"A Profile of Mexican American Health: Data from the Hispanic Health and Nutrition Examination Survey 1982-84" is intended to give a graphic overview of Mexican American health concerns—to highlight some key facts about this population group, their health status and needs, their utilization of health services and participation in health programs, and their involvement in health resources.

The omission of critical analysis for each chart is deliberate. It is hoped that researchers interested in this data will find this chart book an important resource in their work.

The decision to produce this chart book grew out of discussions between the authors and the Division of Disadvantaged Assistance. The authors give special thanks to Dr. Clay E. Simpson Jr., Director, Division of Disadvantaged Assistance, for his encouragement and support of this project.

The content of this publication does not necessarily reflect the view or policies of the Department of Health and Human Services.



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# CHAPTER 1

## Introduction

The health conditions and health status of Hispanics in the United States will assume increased importance as their population increases in the decades to come. In 1970, the U.S. Census Bureau reported approximately 11 million persons of Spanish origin. Over half (6.6 million) of the Hispanic population lived in the Southwest (California, Texas, Arizona, New Mexico and Colorado). The Hispanic population of the United States is growing nearly five times faster than the general public, with one of every 14 Americans now of Spanish background. From 1980 (U.S. Census Data) to 1985 the nation's Hispanic population increased almost 16 percent to 16.9 million persons. In the same period the United States population overall grew by only 3.3 percent. The size of the Hispanic population is reflected also by the number of interviews that had to be conducted in Spanish (See Chart 1.1).

Current census figures indicate an Hispanic population of almost 17 million persons. This figure is generally believed to be an under estimate because of problems related to factors such as an inability to assess accurately the numbers of illegal aliens and establishing ethnic identification. There is general agreement, however, that before the turn of the century Hispanics will be the nation's largest minority group. The status of their health cannot be simply dismissed or overlooked. Until recently there was no national comprehensive study of the status of Hispanic health conditions.

## Previous Studies of Hispanic Health

One of the early and most cited works in vital statistics is that of Moustafa and Weiss (1968) from the School of Public Health at the University of California. Their empirical work of the health status of Mexican Americans also highlighted the need for vital statistics and health data of the Spanish origin population. Moustafa and Weiss used two statewide surveys of vital statistics information (Colorado and California). The Colorado survey was based on mortality data obtained from 1960 death certificates identified by Spanish surname. The California Health Survey done in 1954-1955 is probably the first comprehensive statewide body of morbidity data gathered on the Spanish surname population.

One of the few analytical studies on the mortality of Spanish surname persons is a study by Roberts, McBee, and MacDonald (1970) which investigated the interrelationships of social class, ethnicity, and mortality in Houston, Texas. Death records for 1959, 1960, and 1961 were obtained from the local health department. Age-adjusted rates were then analyzed using census tracts to determine social class standing as well as ethnic population proportions per census tract. The study also illustrated the relationship between mortality and various social demographic features.

Juarez (1978) conducted a review of past research conducted on the health status of the Spanish origin population. Although none of the studies dealt with the elderly, the studies helped provide a background on "health history" of a population subgroup. The various studies dealt with neonatal and infant death rates in San Antonio including, lung cancer mortality among Mexican Americans, Blacks, and Anglos, and overall mortality for all three groups. Juarez, similar to Moustafa and Weiss, stressed the need for comprehensive health statistics of the Spanish origin population in the United States. What existed was a number of sporadic and disjointed efforts.

In 1974 congressional mandate PL 94-311 called for the active production of data on the health of America's Hispanics. Despite the intensive efforts during the past decade to develop a body of knowledge there have been significant gaps. The need for baseline data was noted often by researchers and experts in the field (Solis, 1978; Task Panel Report, Lecca and Olmedo, to the President's Commission on Mental Health, 1978; Bell, Kassachav and Zellman, 1976).

Beyond the basic data needs on morbidity and mortality, there is a need for more comprehensive data. Hayes-Bautista (1978) noted that morbidity and mortality data tell the end result, but little about the process by which those results were obtained. Basic quality of life data such as information about employment, education, income, housing, immigration, and voting participation is also needed. Hayes-Bautista further noted that these data were collected by different agencies, utilizing different population definitions and, without these data, health service programs were likely to end up treating effects rather than causes. A vehicle existed however, that would enable some of the knowledge gaps to be filled. Since the 1950s The National Center for Health Statistics (NCHS) has conducted several health and nutrition surveys of which the recent Hispanic Health and Nutrition Examination Survey (HHANES) is one.

## Hispanic Health and Nutrition Examination Survey

The NCHS health survey has as its foundation The National Health Survey Act of 1956, which has been updated periodically since its original passage by Congress. Throughout the history of the National Health Survey, the mandate of the 1956 Congressional Act had been fulfilled for the general United States population with the provision of data on a wide range of health status measures. However, there was a notable lack of comparable data for the Hispanic population. Previous National Health and Nutrition Examination (NHANES) samples did not include a sufficient number of Hispanics to enable an adequate estimation of their health characteristics.

The goal of the Hispanic Health and Nutrition Examination Survey (HHANES) was to produce, for the three Hispanic subgroups (Mexican American, Puerto Rican and Cuban), estimates of health and nutritional status that are comparable to estimates available for the general population. The HHANES was the first special population survey ever undertaken by NCHS, and probably the last, based on the cost of its development and implementation. The HHANES relied on five principal data collection methodologies: physical examinations, diagnostic testing, anthropometry, laboratory analysis, and personal interviews. It is important to note that HHANES data can be compared with data collected from the general population through the NHANES, The National Health Interview Survey, The National Survey of Family Growth and other federally sponsored surveys.

The major difference between HHANES and other HANES data is that the HHANES is a survey of three special subgroups of the population in selected areas of the United States. The HHANES was a probability sample consisting of civilian non-institutionalized Hispanics (Mexican Americans in the Southwest, Puerto Ricans in New York City, and Cuban Americans in Dade County, Florida).

## **Goal and Objective of the Chart Book**

The goal of this chart book is to present data from the HHANES, with the most up to date information on Mexican Americans in chart form for researchers, agencies, organizations, public and private and community groups interested in this profile of data.

The objectives are:

- to present a current profile of Mexican Americans
- to present a pictorial view of the HHANES data
- to stimulate additional research, and
- to provide a basis for analysis and discussion.

It is hoped that this chart book will serve as a beginning resource for the many Hispanic researchers seeking data on this population group, as well as those groups seeking justifications for statistical analysis or program development.

Finally, the authors have expectations of publishing other volumes from the Puerto Rican and Cuban American data of the HHANES.

## **Design of The Mexican American HHANES Sample**

The Mexican American HHANES sampling procedure is a multi-stage probability sample of civilian non-institutionalized Mexican Americans in the states of Arizona, California, Colorado, New Mexico, and Texas. The HHANES Mexican-origin universe of 193 first-stage sampling units (counties and county groups) or Primary Sampling Units included about 84 percent of the 1980 Mexican American population of the United States.

These 193 Primary Sampling Units were then stratified on the basis of number of Hispanics, percent Hispanic, ratio of the 1980 to 1970 Hispanic population, median income, and percent urban based on 1980 Census of Population and Housing estimates. Fourteen Primary Sampling Units were then selected for inclusion in the sample: one each in Arizona, Colorado and New Mexico, six from Texas, and five from California.

At the Primary Sampling Unit level, block groups and enumeration groups were stratified on the basis of an economic index and Hispanic density. Secondary sampling units were then selected on the basis of age distributions within SSU's. Within secondary sampling units households had an approximately equal probability of inclusion in the sample.

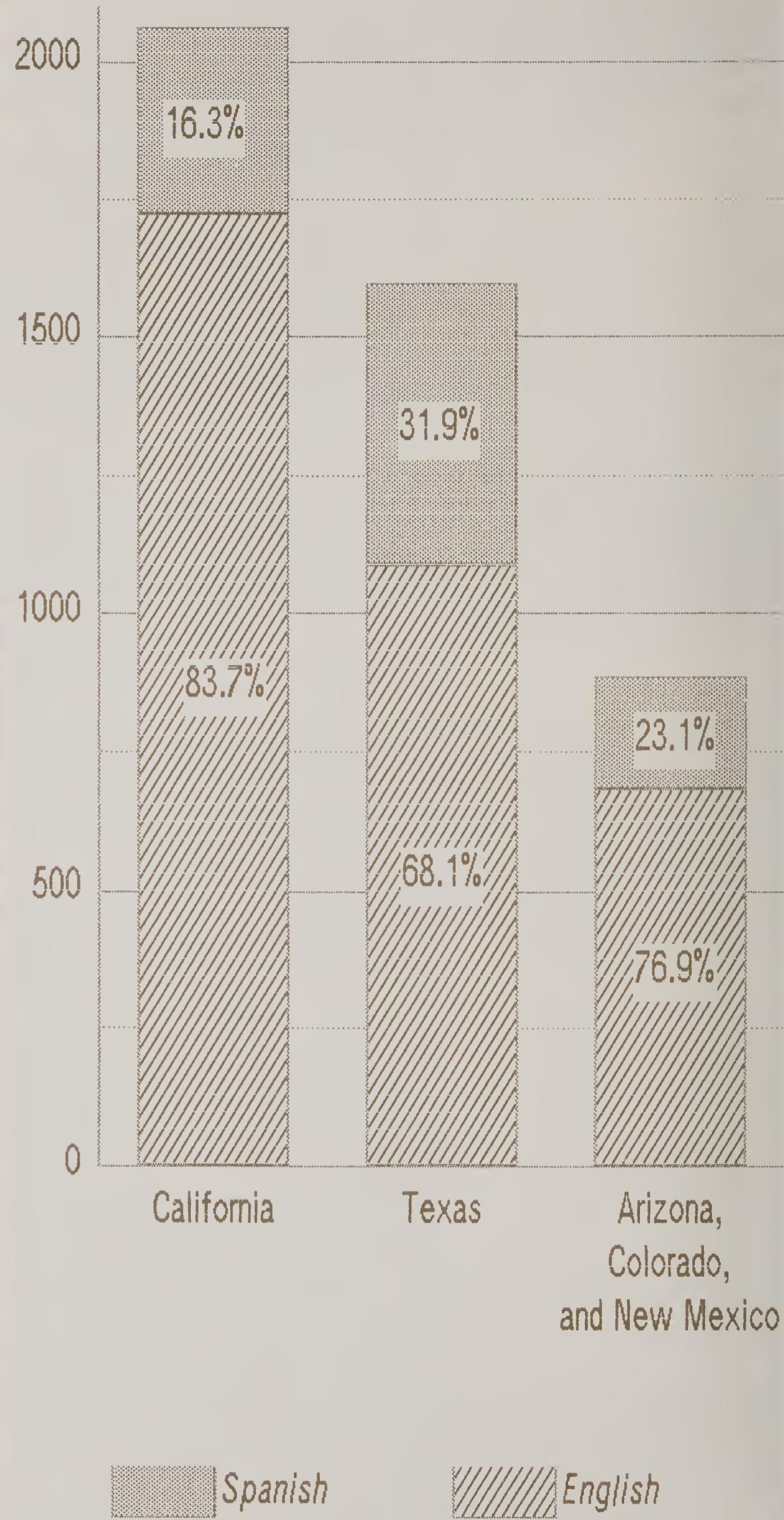
After sample households had been identified, the ethnic composition of the household was determined by interviewers using the Household Screener Questionnaire to select eligible Mexican-origin families. Members of the families were selected using an oversample of those individuals under 20 years of age and those 45 to 74 years of age.

The actual interviews and examinations were conducted from July 1982 through November 1983. Of the 9,894 persons included in the sample, 8,554 were interviewed; of these, 7,462 were examined.

The data reported in this monograph reflect only those Mexican-origin HHANES respondents 18 years of age or older. With the exception of Chart 1.1 (which reports sample data in terms of numbers of respondents) all charts reflect the estimated population values based on sample values and the appropriate sample weights. Thus, the percentages and means reported are population estimates.

**Number of Completed Interviews by State of Residence and Language of Interview**

Approximately 77 percent of all interviews were conducted in English; 16 percent of those respondents in California, 23 percent of those in Arizona, Colorado and New Mexico, and 32 percent of those in Texas were conducted in Spanish.



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## CHAPTER 2

### Sociodemographic Context

The Hispanic population of the United States, according to recent Census Bureau data, consists of over 16 million persons of Spanish ancestry. Mexican Americans represent the largest subgroup, numbering 10 million. There are 3.3 million Puerto Ricans living in Puerto Rico who are citizens of the United States and over 2 million living in the continental United States, 1 million Cuban Americans, and 3 million other Hispanics in the United States.

Hispanics, having a median age of 23 years, are younger than the United States population as a whole. The median age for Mexican Americans and Puerto Ricans is 22, and their numbers are increasing rapidly. About 6 percent of families have six or more children. It is projected that Hispanic Americans will comprise the largest minority group in the United States by the year 2000.

Mexican Americans have limited education. Eight percent have completed three years or less of schooling, twenty-five percent completed six years or less, and forty-seven percent had completed some high school. This pattern is changing. In 1970, 45 percent were high school graduates, in 1983, 59 percent had graduated from high school. In 1970, only 5 percent of Hispanics were in college, by the mid-80s the proportion increased to 10 percent.

Hispanics live in every state, but 60 percent are concentrated in the five southwestern states of Arizona, California, Colorado, New Mexico, and Texas. In 1980, more than 50 percent resided in Texas and California. One-third of the population of New Mexico is Hispanic. One-fifth of the population of Texas and California is Hispanic. One-tenth of the population of Arizona, Colorado, Florida, and New York is Hispanic. Other states with over 50,000 Hispanics are Illinois, Indiana, Washington, and Ohio.

Nine percent of Mexican Americans have a combined family income of \$5,000.00 or less and twenty percent had incomes below the poverty level.

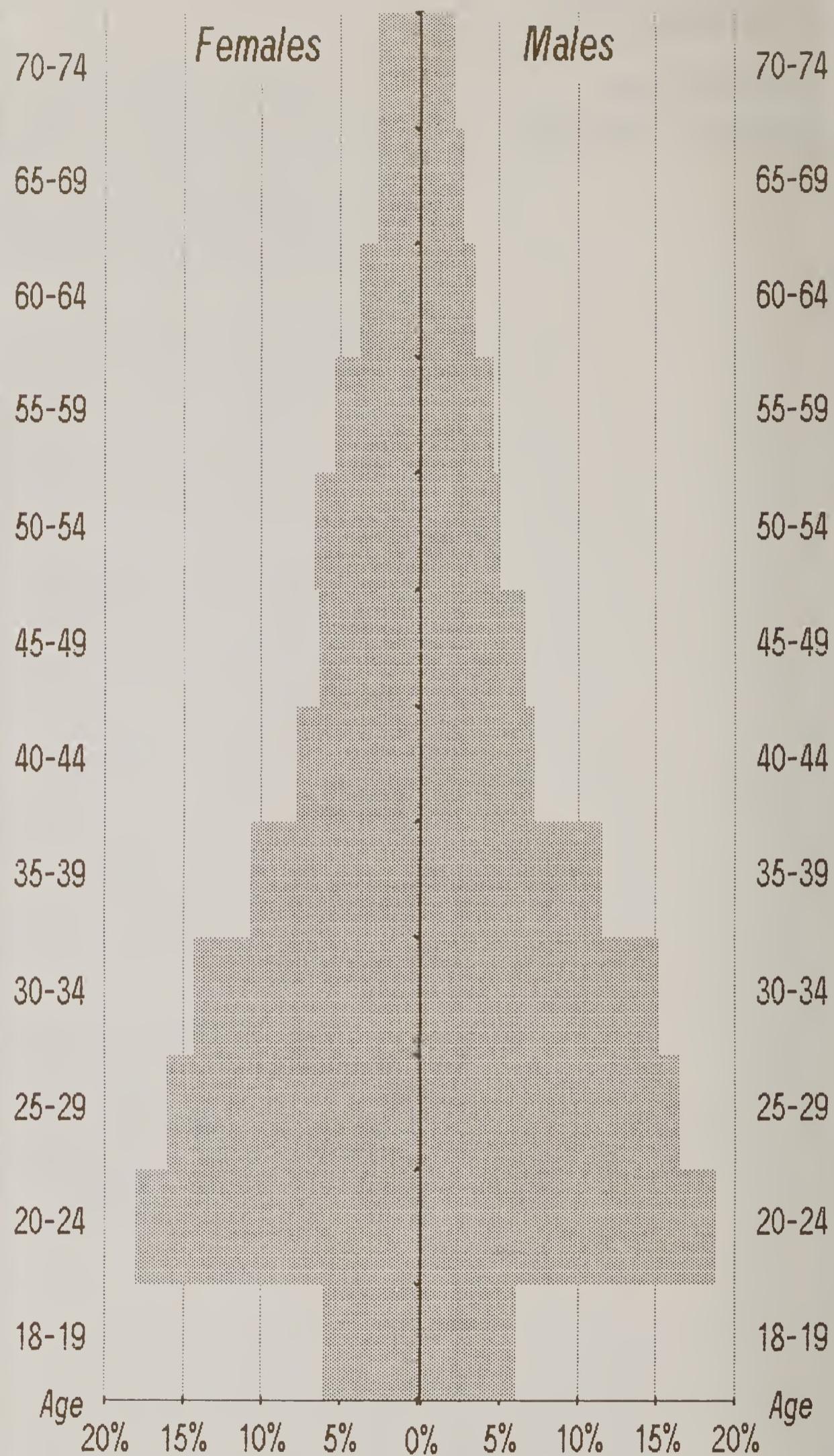
Twenty-three percent of the sample reported four people in their family, and sixty-one percent had four or less.

Examining the generational and nationality factors of Mexican Americans, sixty-one percent said they were born in the United States and thirty-four percent in Mexico, which correlated with twenty-five percent of the respondents indicating their national origin to be Mexican, and sixty-four indicating their national origin to be Mexican American.

## 2.1

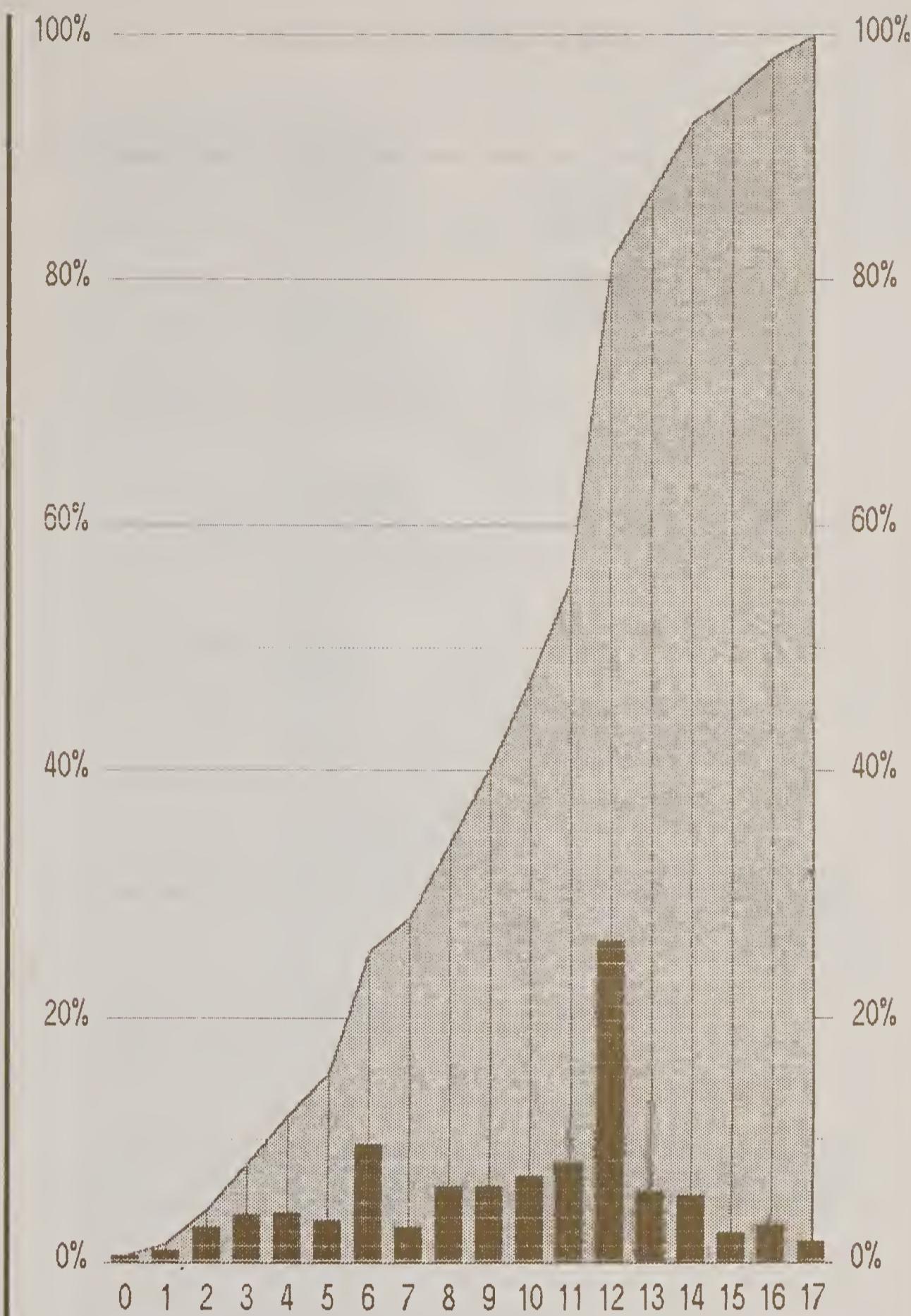
### Population Pyramid

Overall, five percent of the sampled population is over the age of 65.



## Educational Attainment in Years

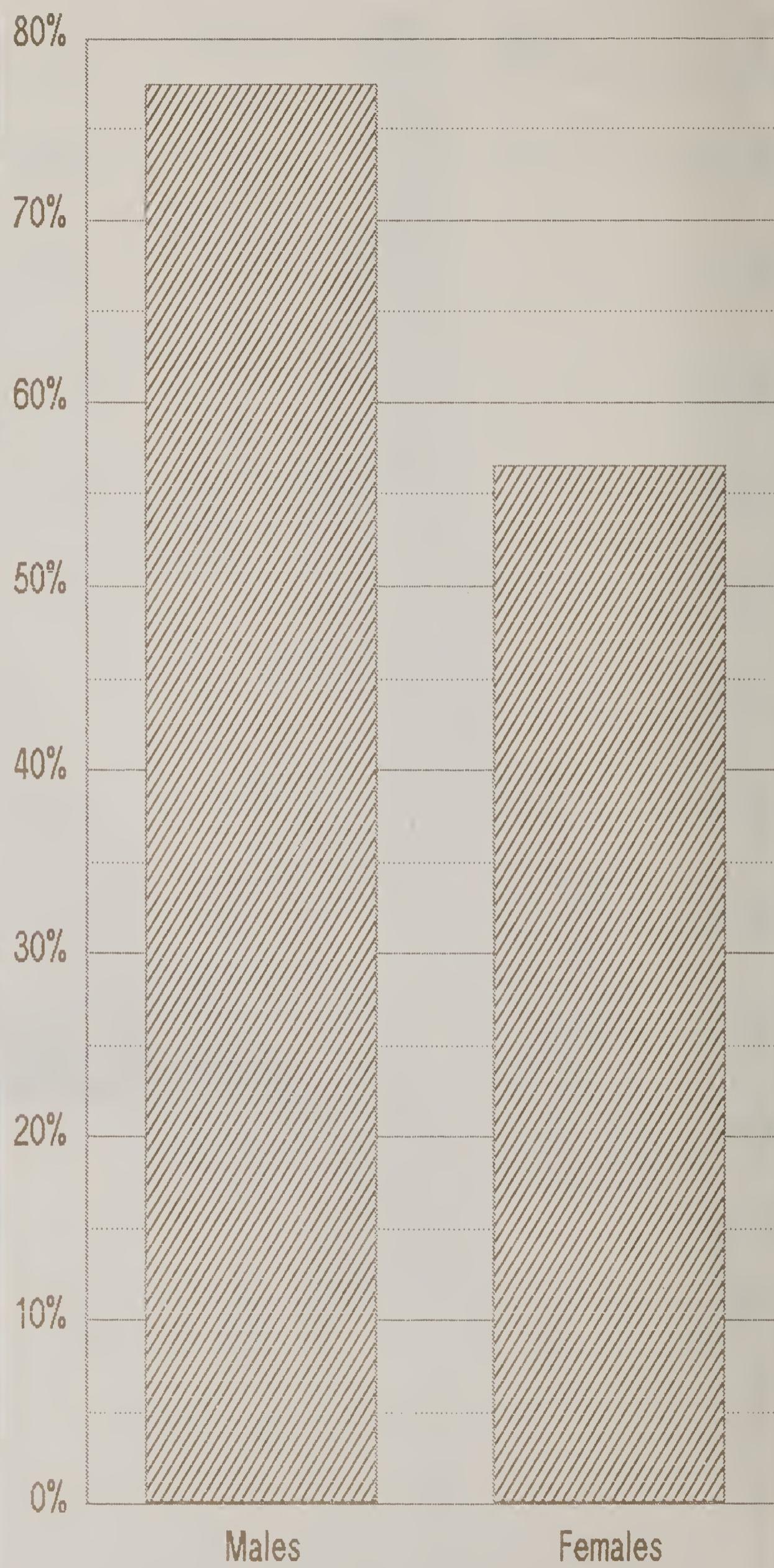
The modal level of education was 12th grade.



## 2.3

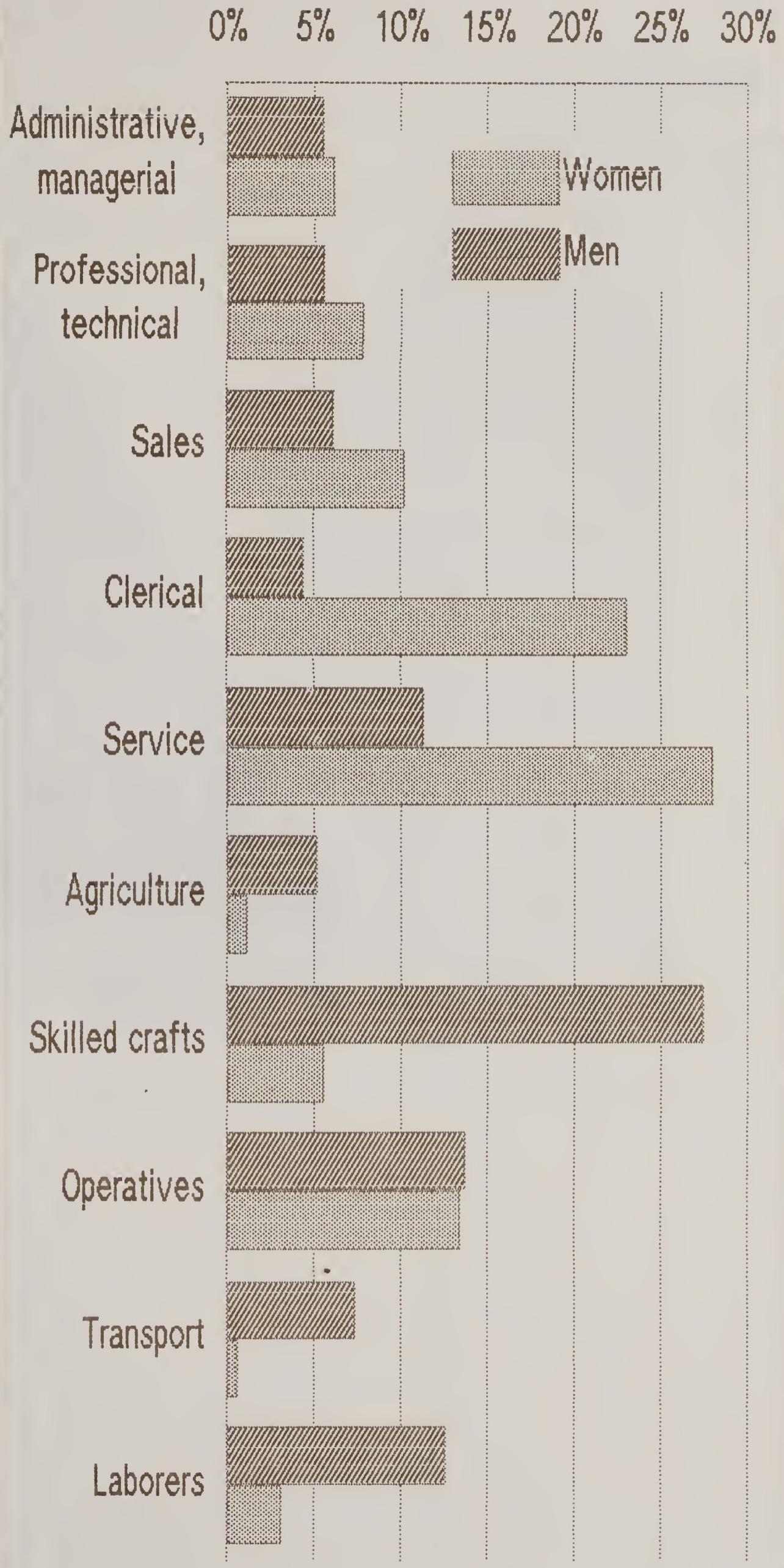
### Labor-force Status by Sex

Seventy-seven percent of males and 56 percent of females were working during the two weeks prior to the interview.



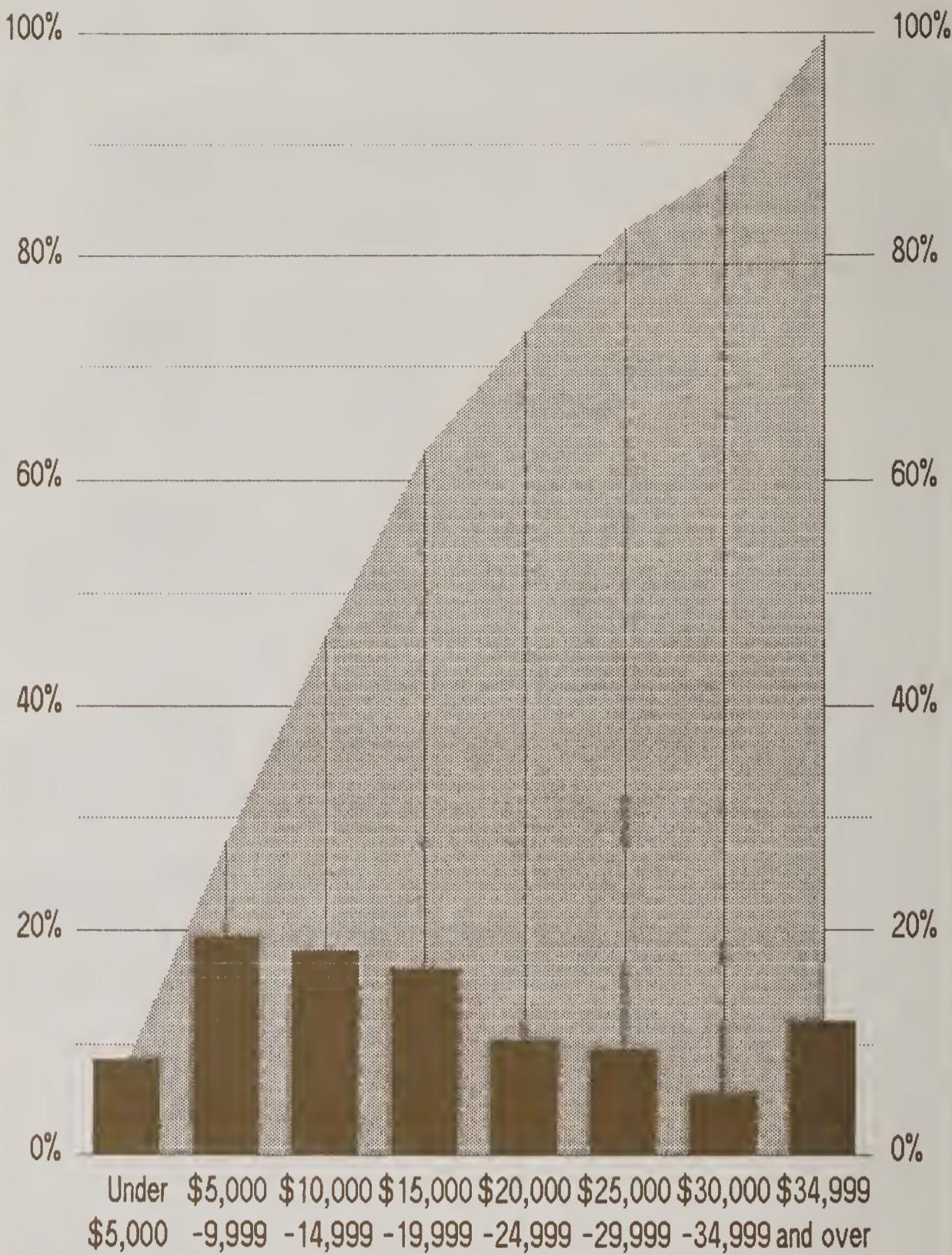
### Occupational Category by Sex

The most common female occupations were clerical and service while males were more likely to be skilled craftsmen.



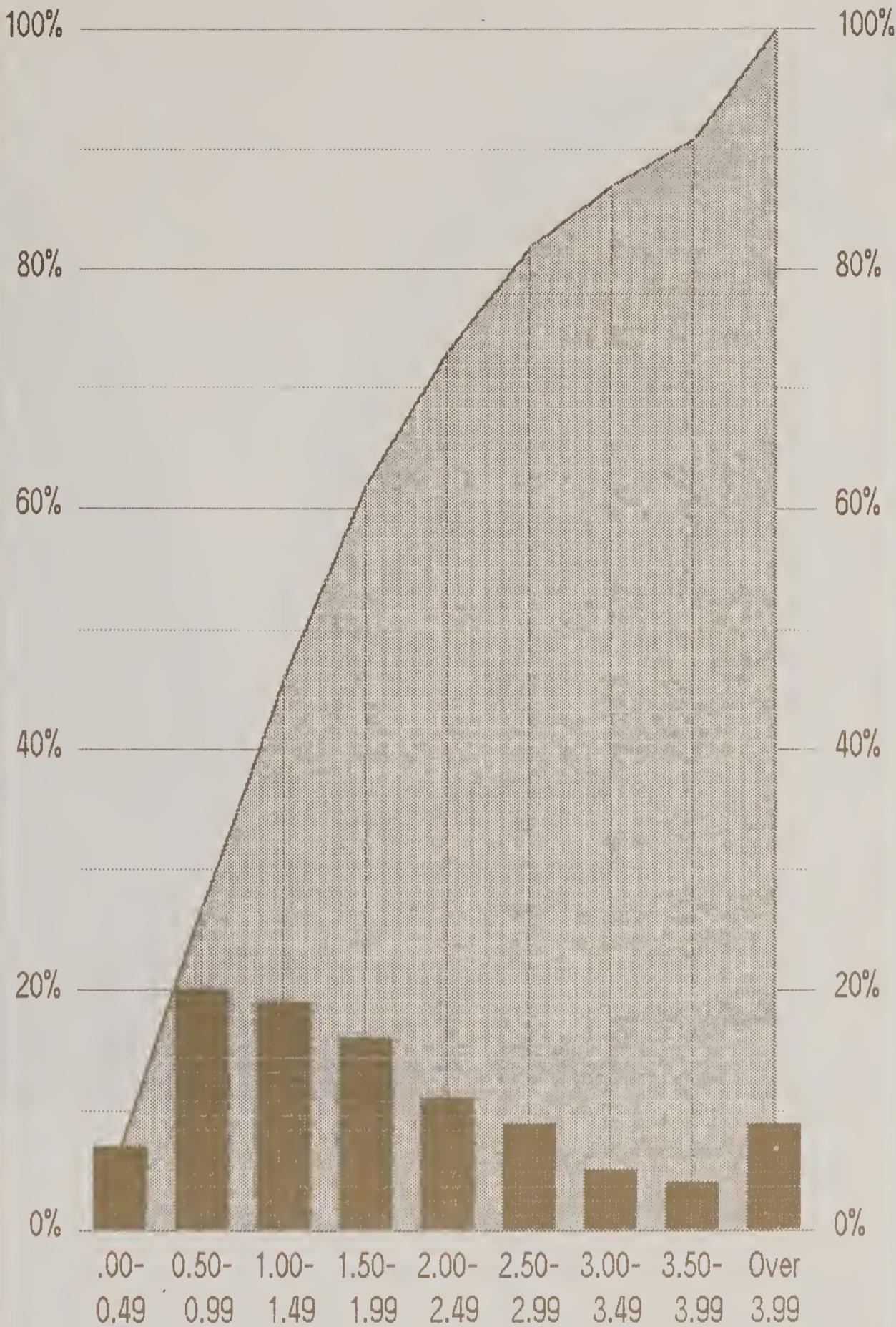
### Family Income and Cumulative Family Income

Approximately 75% had family incomes below \$25,000.



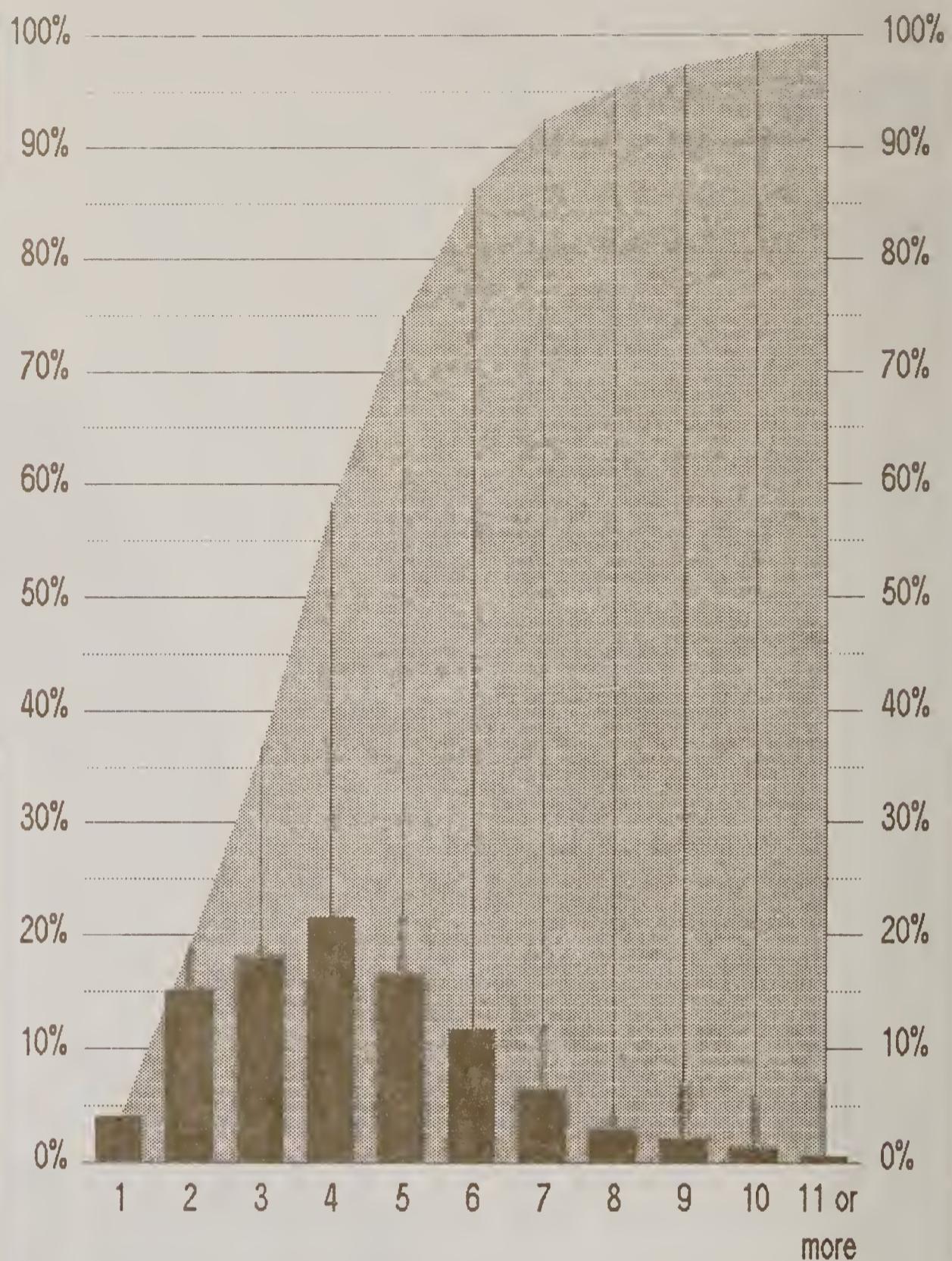
**Distribution and Cumulative Distribution of Households by Poverty Index**

Twenty-seven percent of the respondents were below the poverty level.



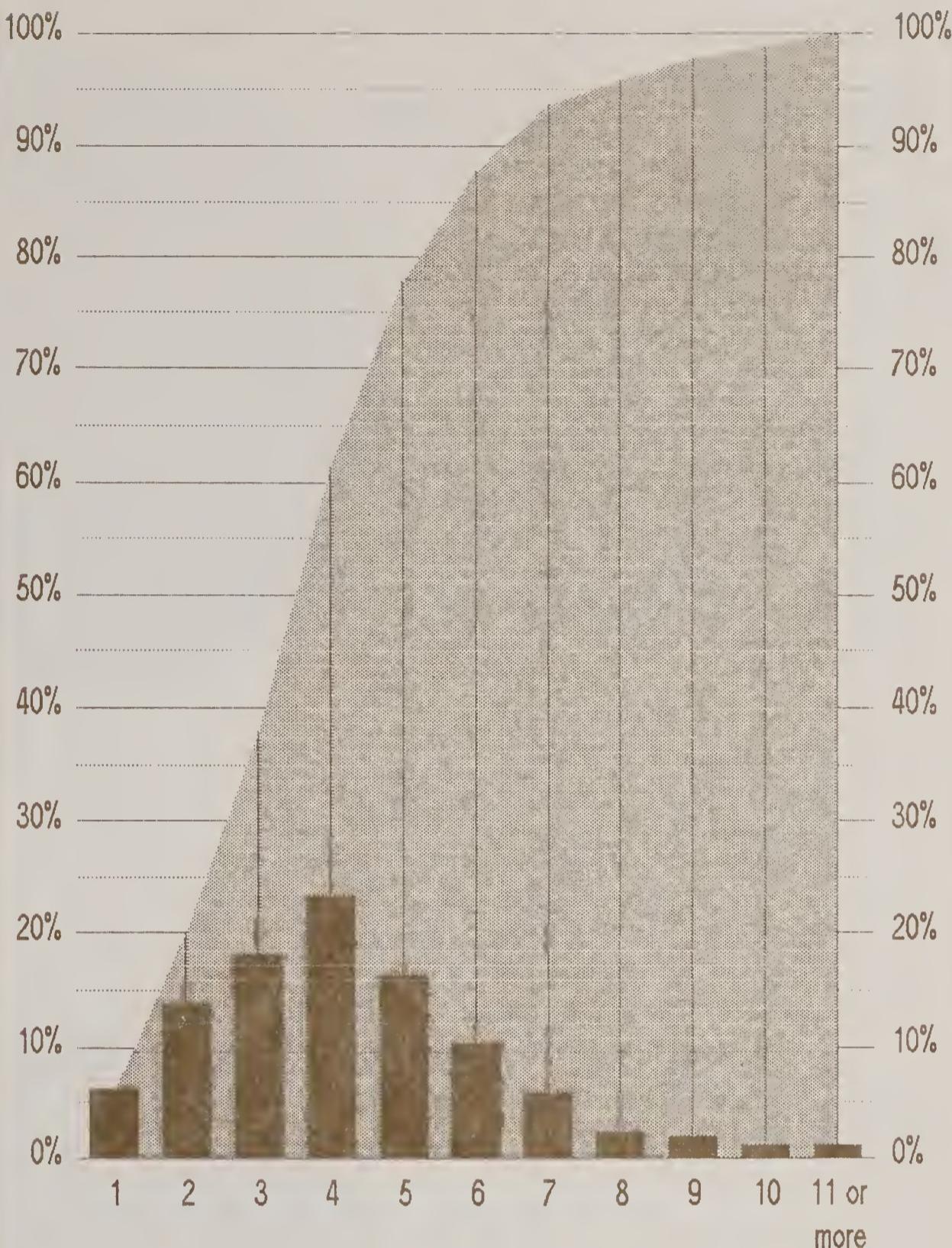
**Family Size and Cumulative Family Size**

Fifty-eight percent of the respondents reported four people or less in their families.



### Household Size and Cumulative Household Size

Almost 80% of the respondents indicated 5 people or less living in their household.

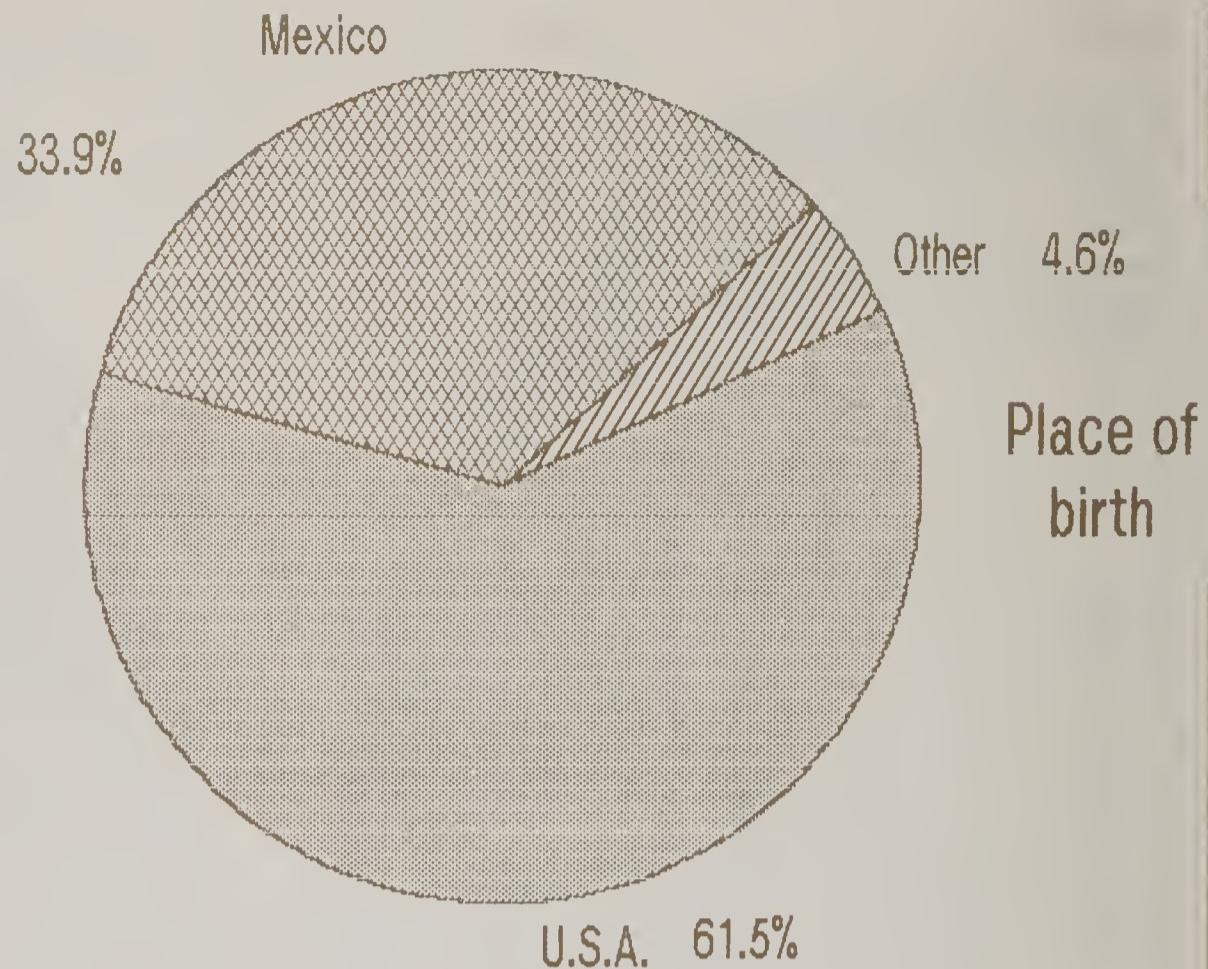


2.9

**Place of Birth and Ancestry**

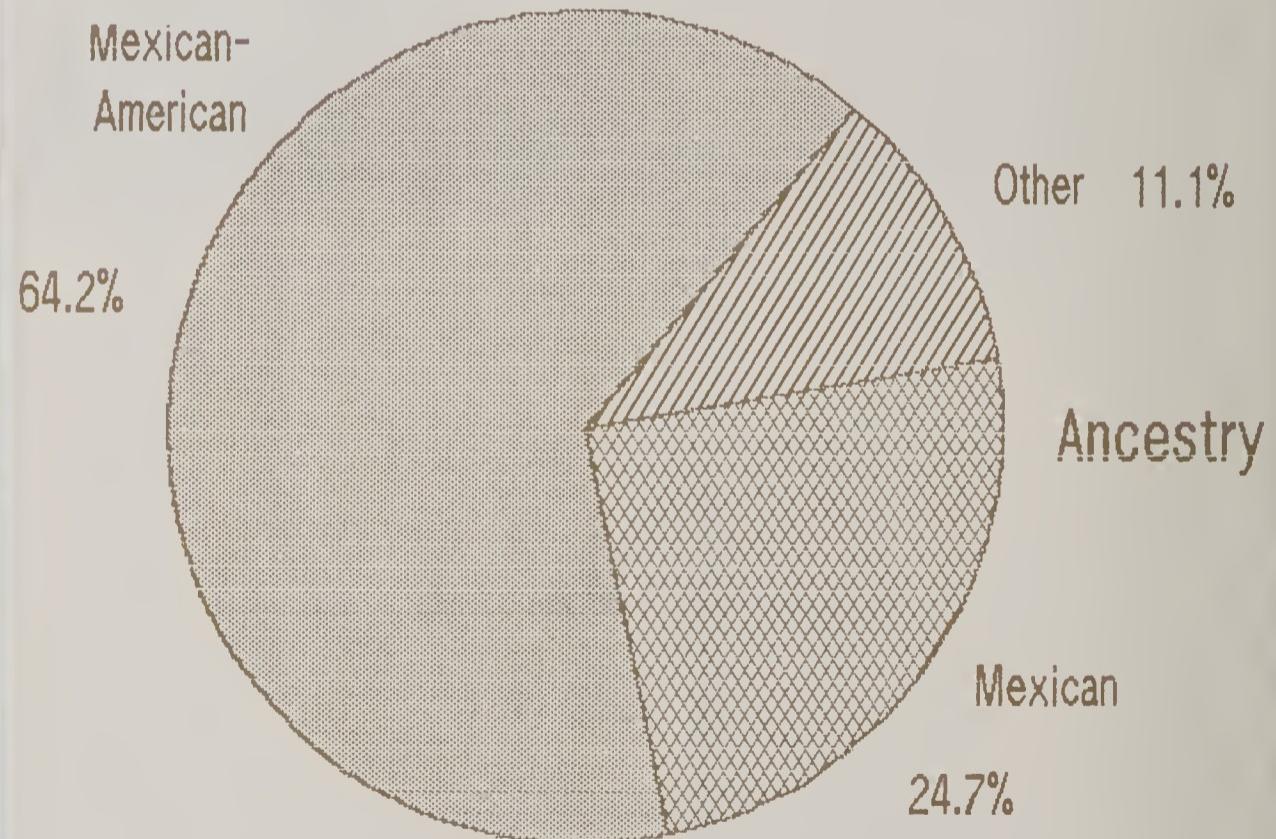
a.

Approximately sixty-one percent were born in the United States and thirty-four percent in Mexico.



b.

Twenty-five percent of the respondents claimed Mexican ancestry.



## CHAPTER 3

### Health Status

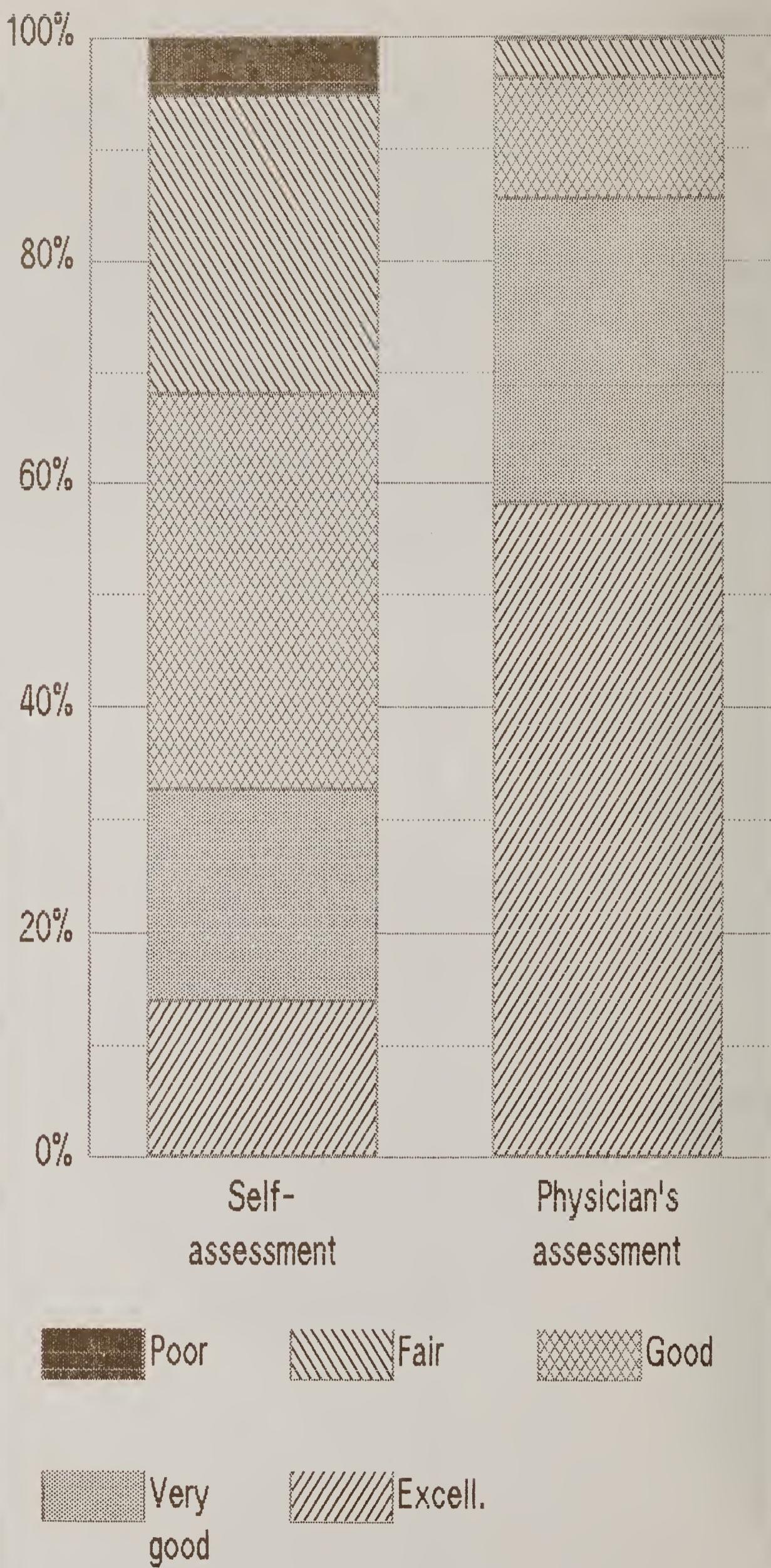
Many of the charts in this section compare the health status rates of males and females overall and relative to age levels. Females report higher rates of health problems than do males in a significant number of disease categories. No attempt is made to explain this variation, however the authors believe there is a pressing need for further study in this area that goes beyond the descriptive presentations made in this document.

Although health care utilization rates are given in another section the reader will likely be interested here in the failure of some respondents to seek medical evaluation for conditions that are considered severe and/or life threatening. This pattern is also seen relative to routine prevention medical procedures. It poses a particularly interesting proposition when this avoidance tendency is considered in combination with the fact that respondents perceive themselves as being in poorer health than the physicians who examined them. Medical compliance rate data also provides additional insight into understanding Mexican American health status.

### 3.1

#### Self-assessment and Physician's Assessment of General Health Status

Subjects perceived themselves to be in poorer health than did the physicians who examined them.



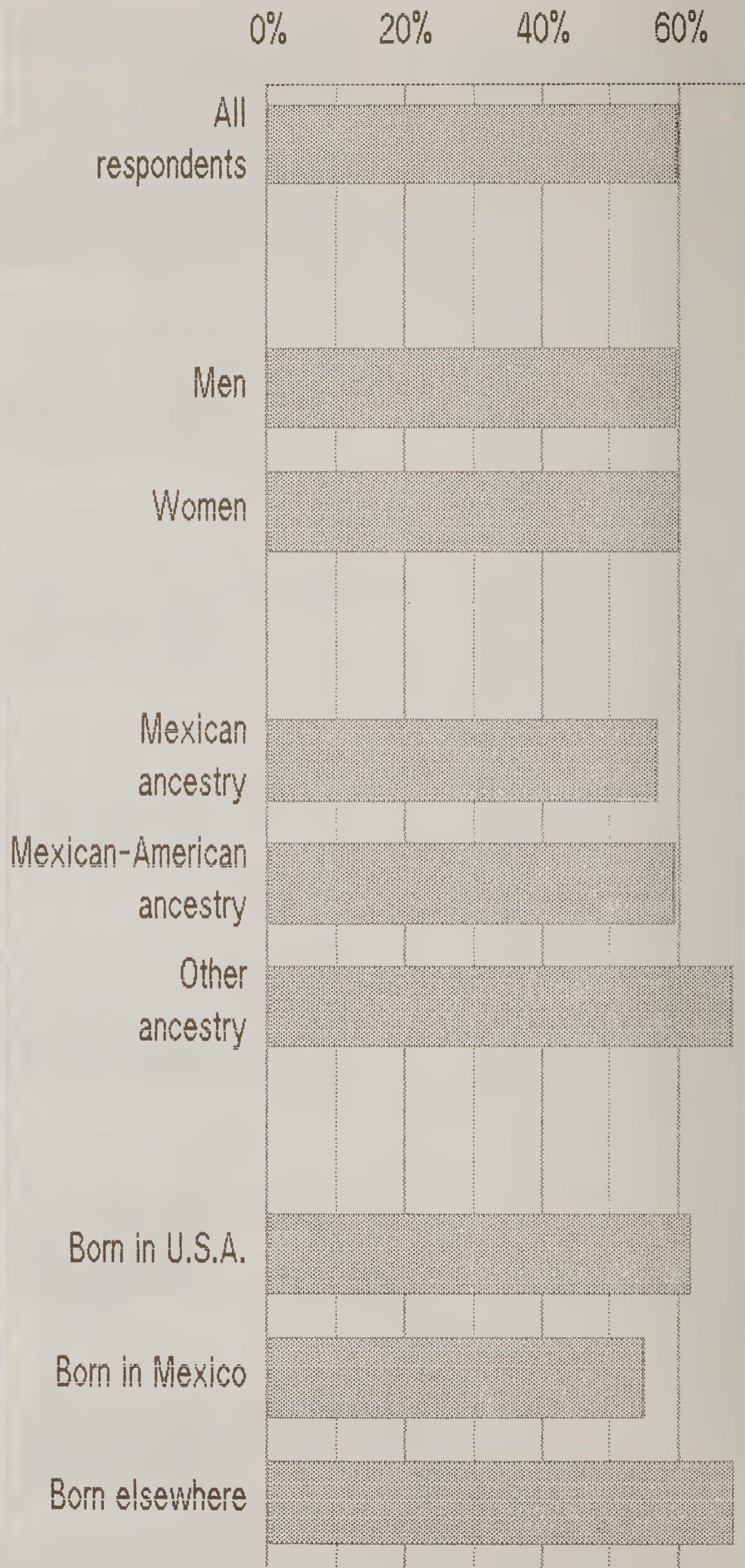
### Age-Sex Specific Rates for "Excellent" Health Status

The frequency of excellent health ratings are similar for both sexes, however, there is some variation by age.



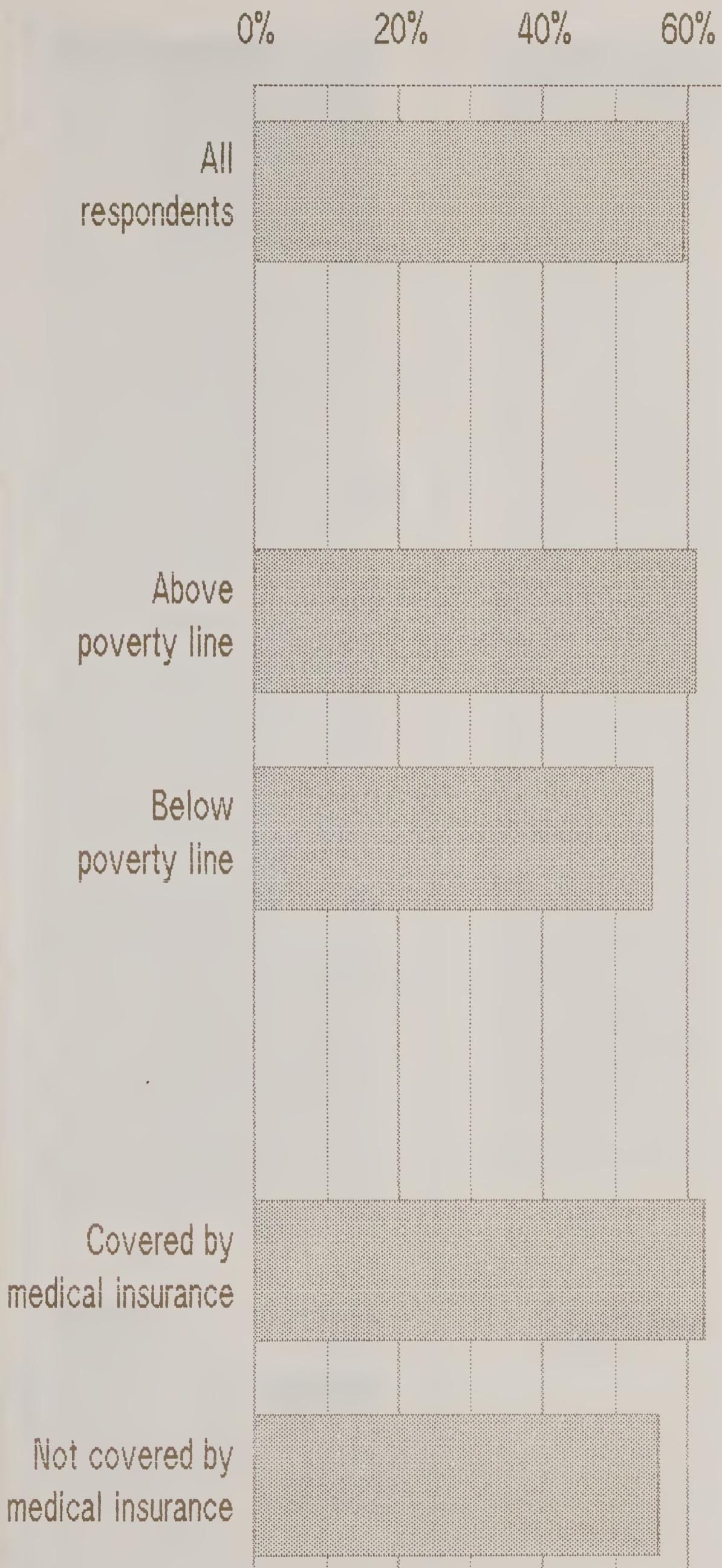
### Relationship of General Health Status to Sex, Ancestry, and Place of Birth

General health ratings are similar for both sexes. There is minor variation by ancestry: individuals born in Mexico are less likely to receive excellent ratings.



**Relationship of General Health Status to Poverty Level and Health Insurance Coverage**

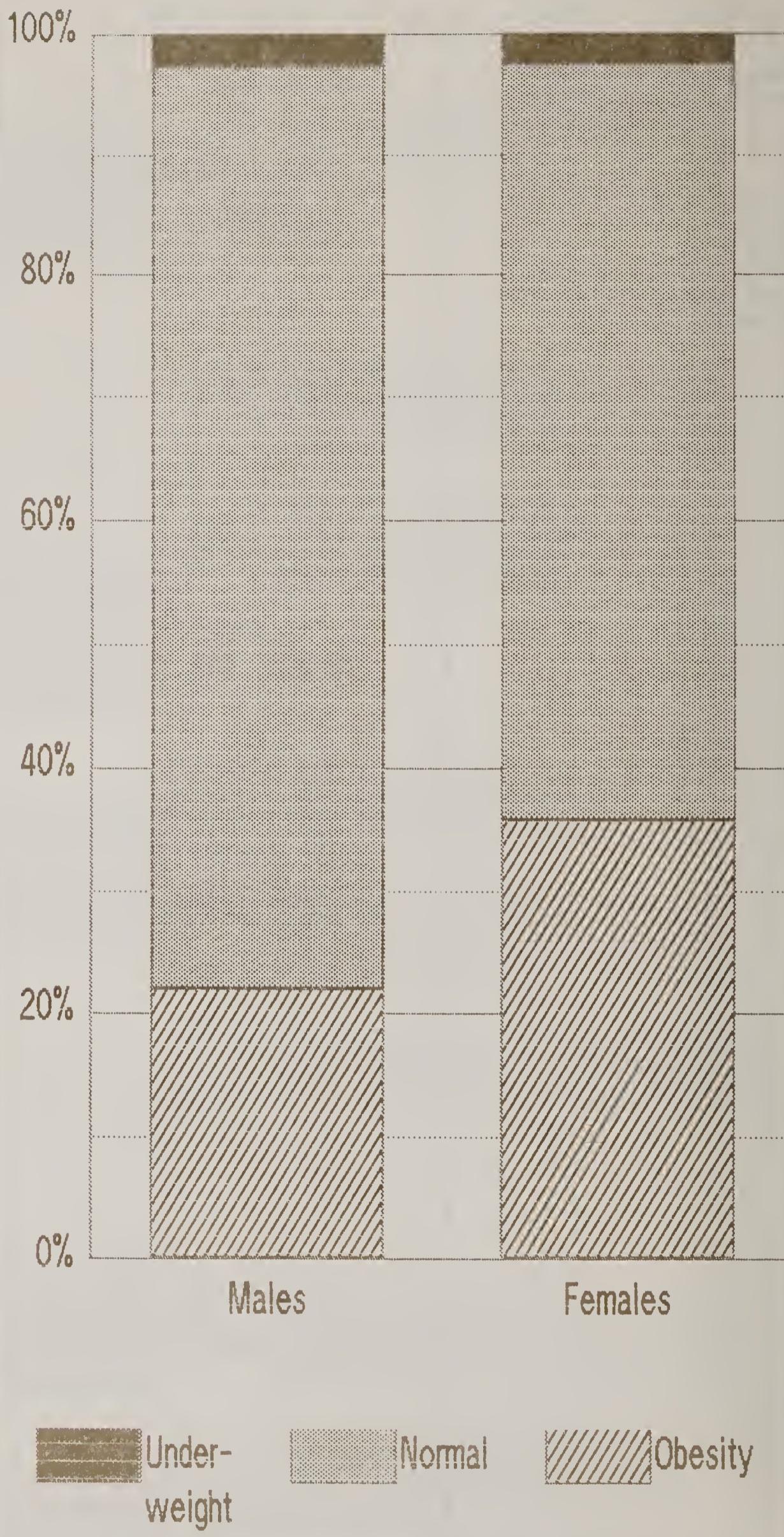
Excellent health ratings were slightly more common for those above the poverty line. Excellent ratings were positively related to the presence of insurance coverage.



### 3.5

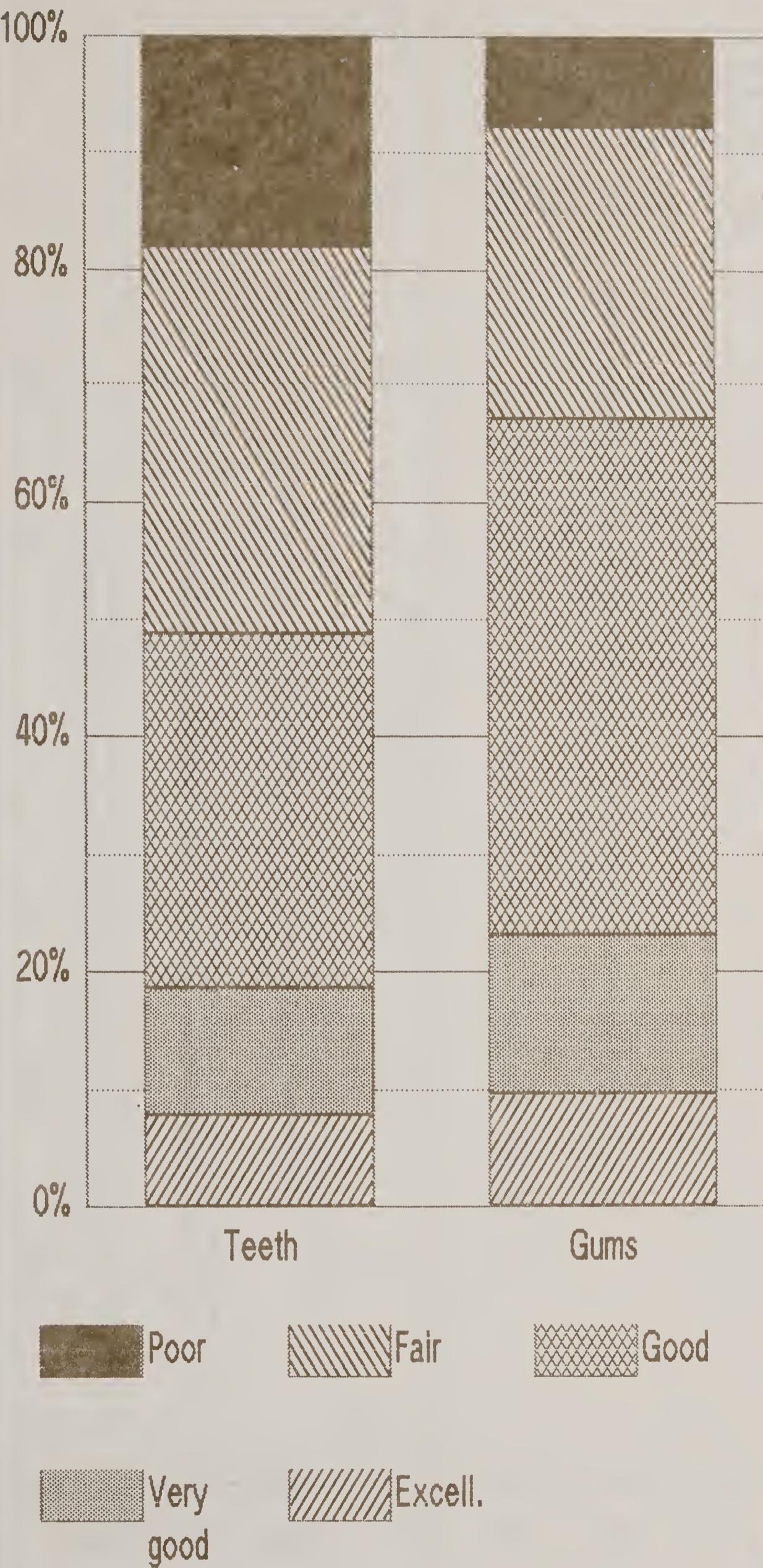
#### Physician's Assessment of Weight Status

Obesity is more common among females.



**Self-assessment of Condition of Teeth and Gums**

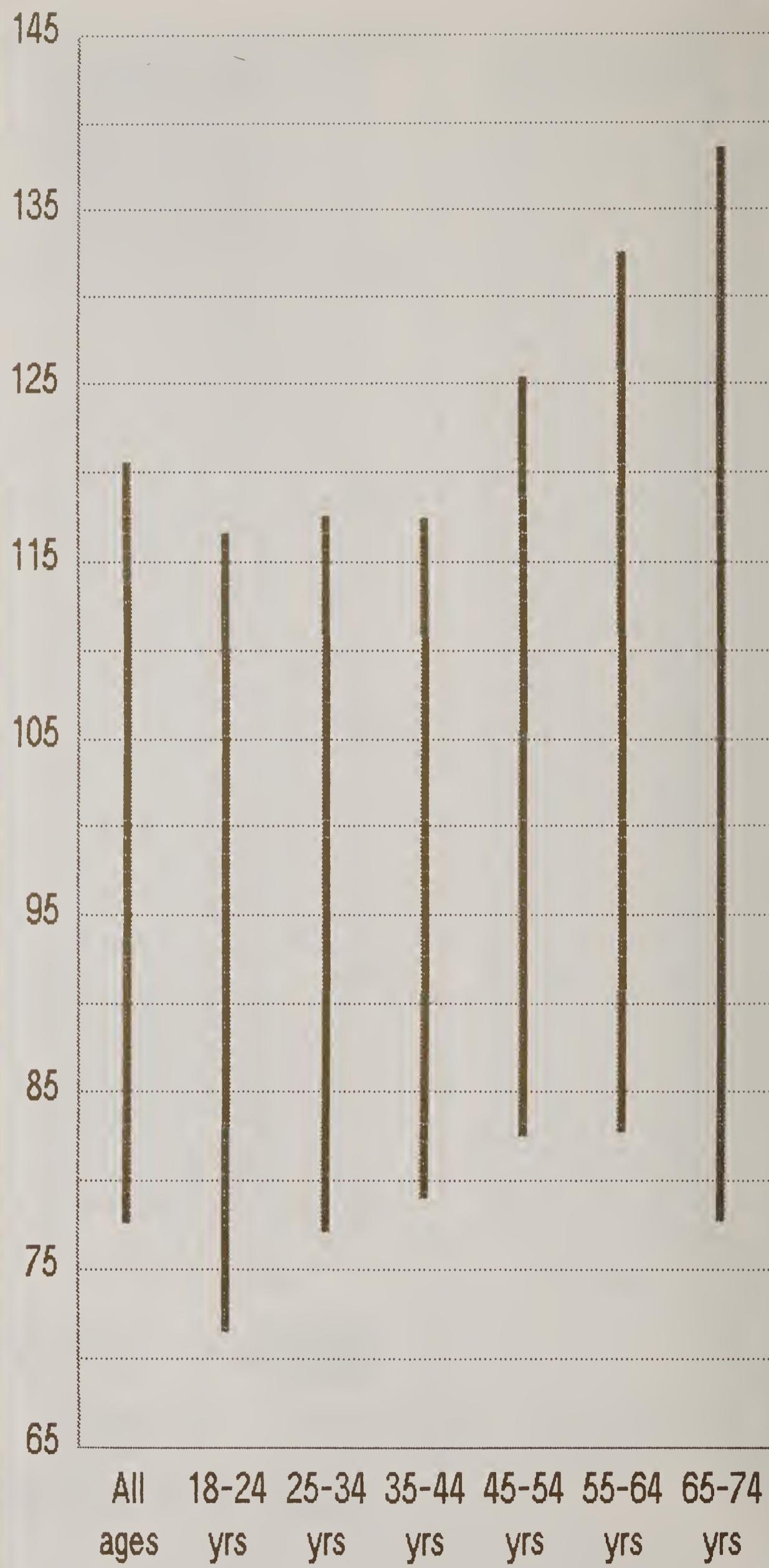
Almost 50% rated their teeth as between good and excellent.



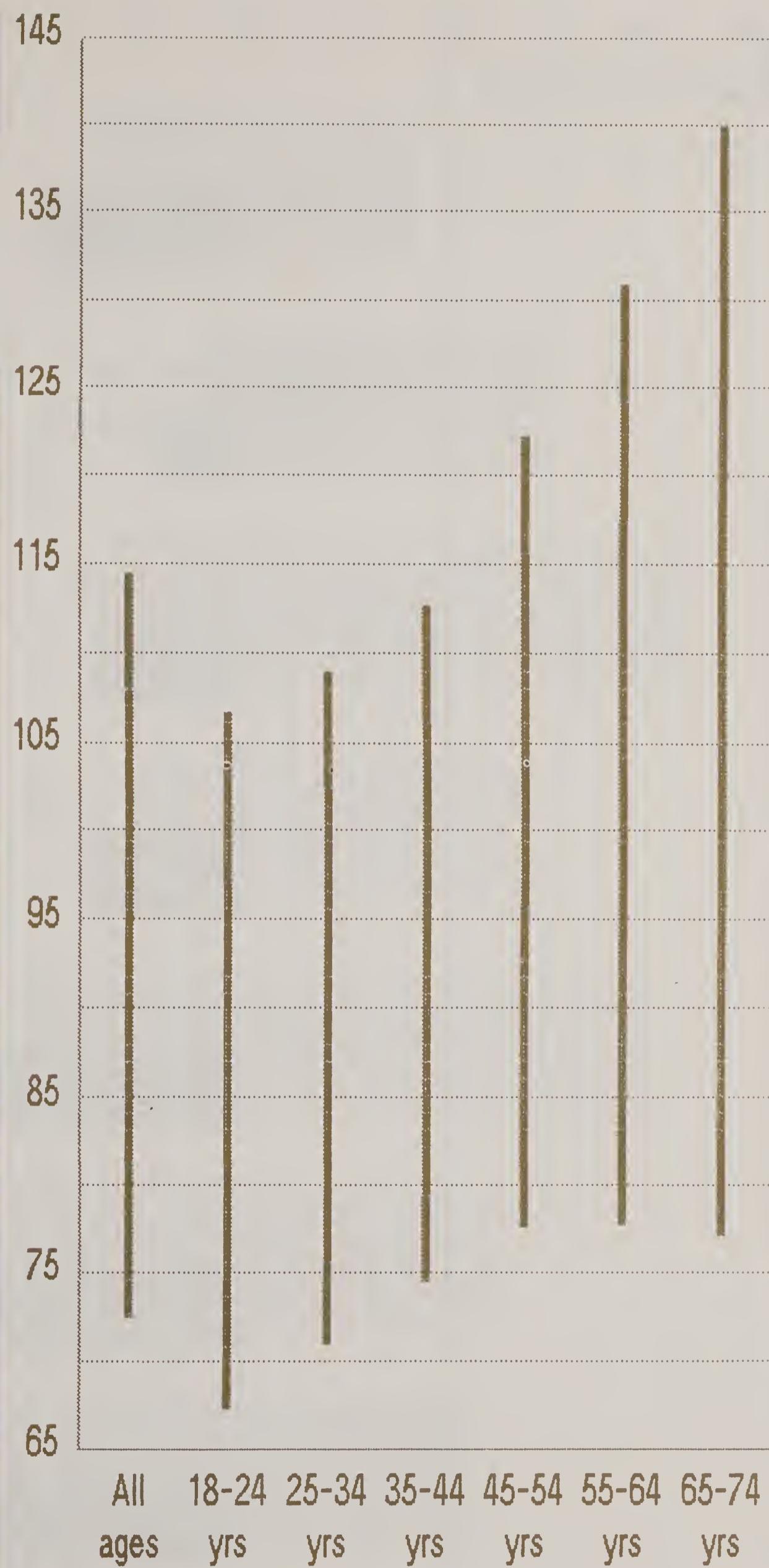
### 3.7

#### Age-Sex Mean Diastolic and Systolic Blood Pressure Levels for Male Respondents

Diastolic and systolic pressure is higher for males until age 65.



**Age-Sex Mean Diastolic  
and Systolic Blood Pres-  
sure Levels for Female  
Respondents**



### Age-Sex Specific Rates for Diagnosis of Hypertension

Females are more likely to be hypertensive than males.



### Salt Reduction, Use of Medication, and Weight Control by Hypertensives

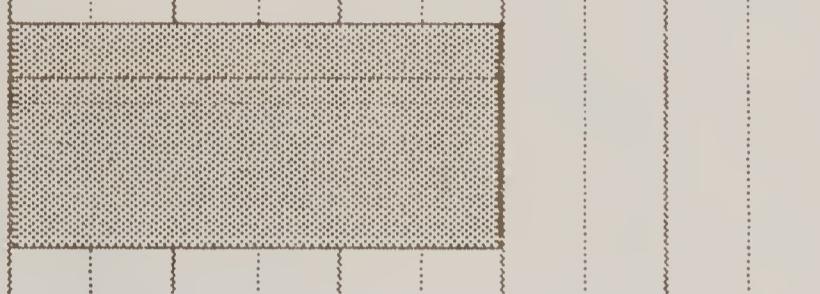
Compliance rates are higher for salt intake reduction and medication usage than for weight loss.

0% 20% 40% 60% 80% 100%

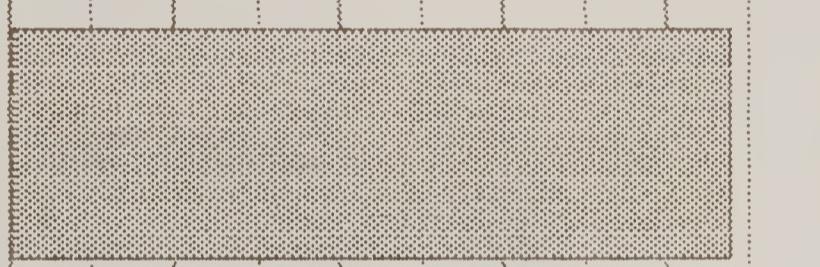
See doctor regularly about blood pressure?



Ever told to use less salt?



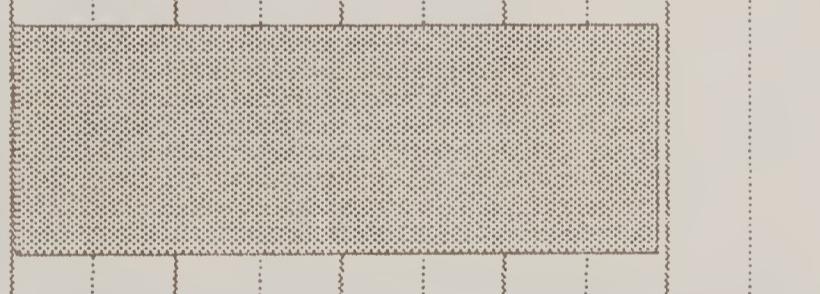
Reduce salt intake?



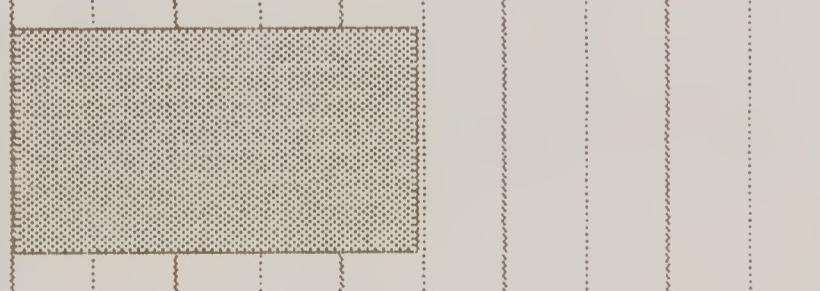
Was medication prescribed?



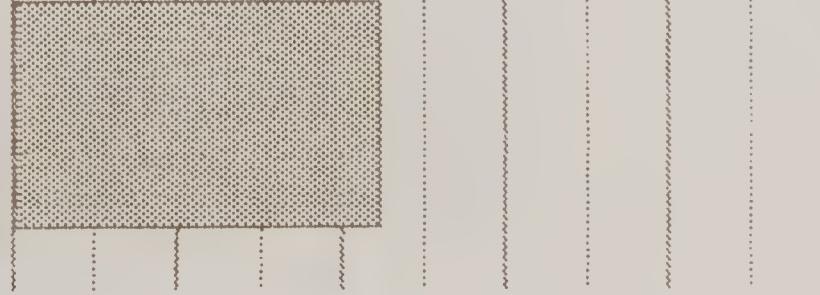
Take medication regularly?



Advised to lose weight?



Did you lose weight?



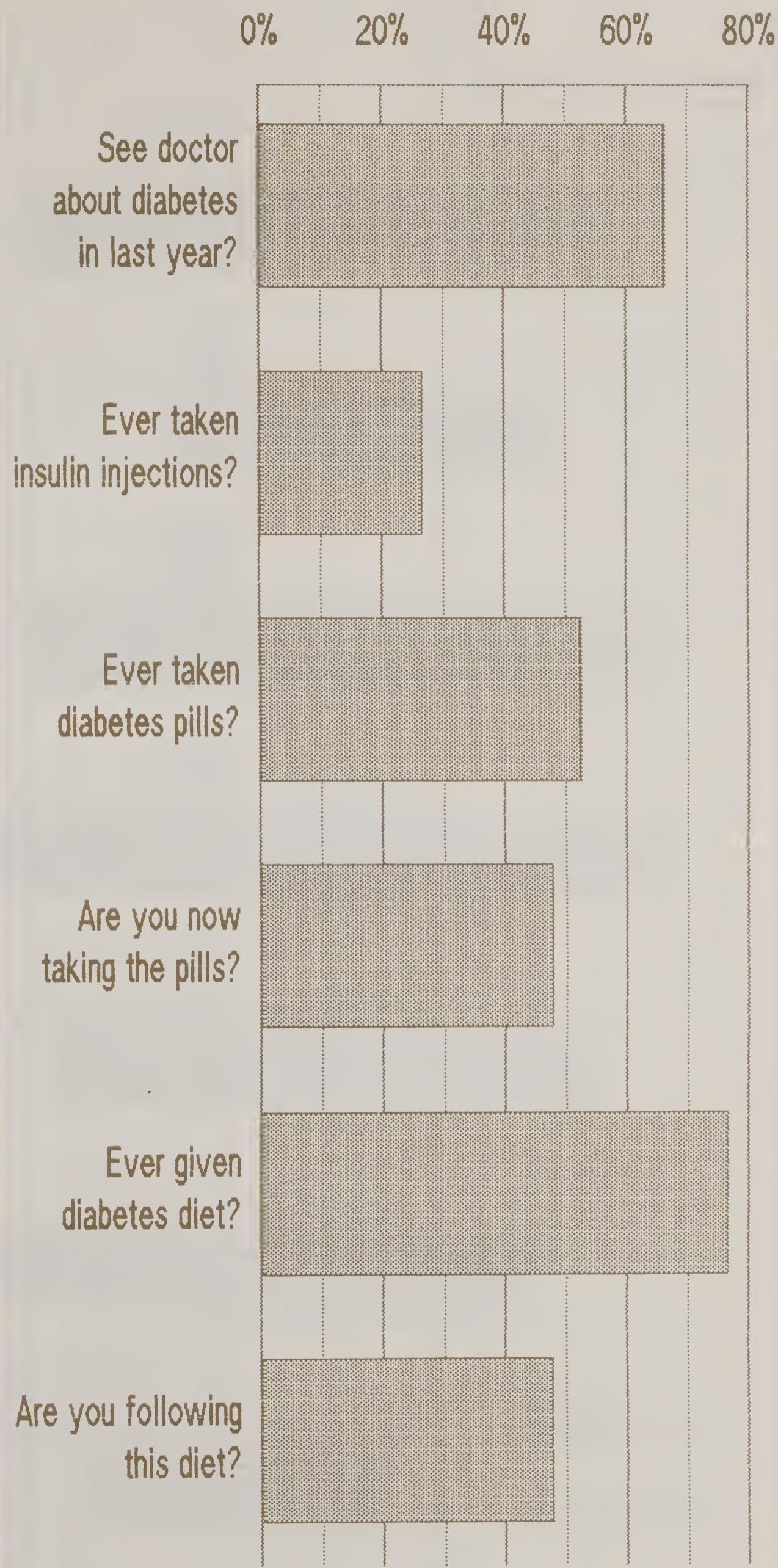
### Age-Sex Specific Rates for Diabetes

About 4% of males are diabetic contrasted with 6% of females.



**Insulin Injections, Use of Medication, and Dietary Practices by Diabetics**

More diabetics are controlled by pills or diet than by insulin injections.



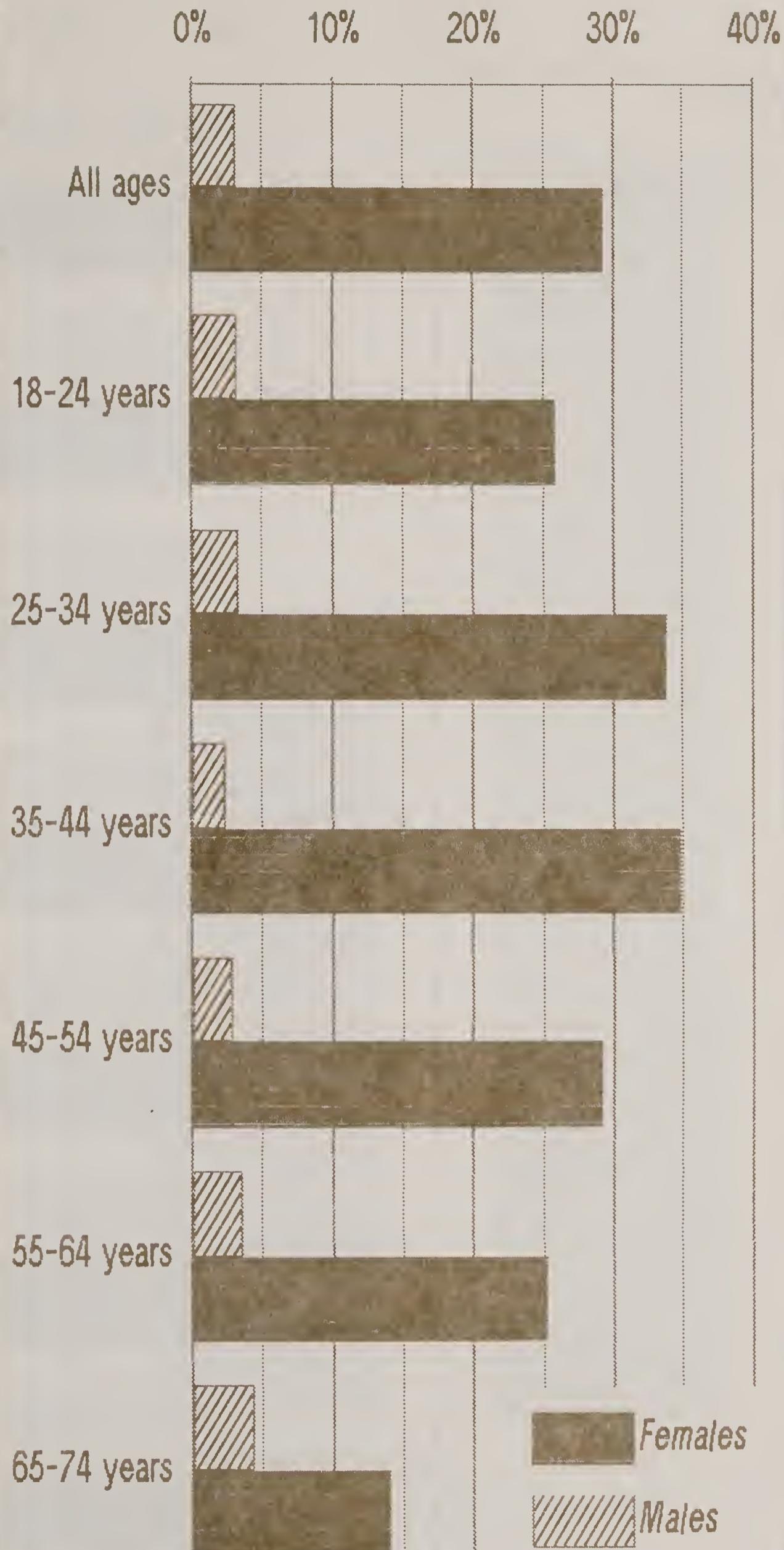
### Age-Sex Specific Rates for Diagnosis of Tuberculosis

Females have a higher tuberculosis rate than do males. After age 65 this trend changes markedly.



**Age-Sex Specific Rates for Anemia**

At every age level more females are anemic than are males.



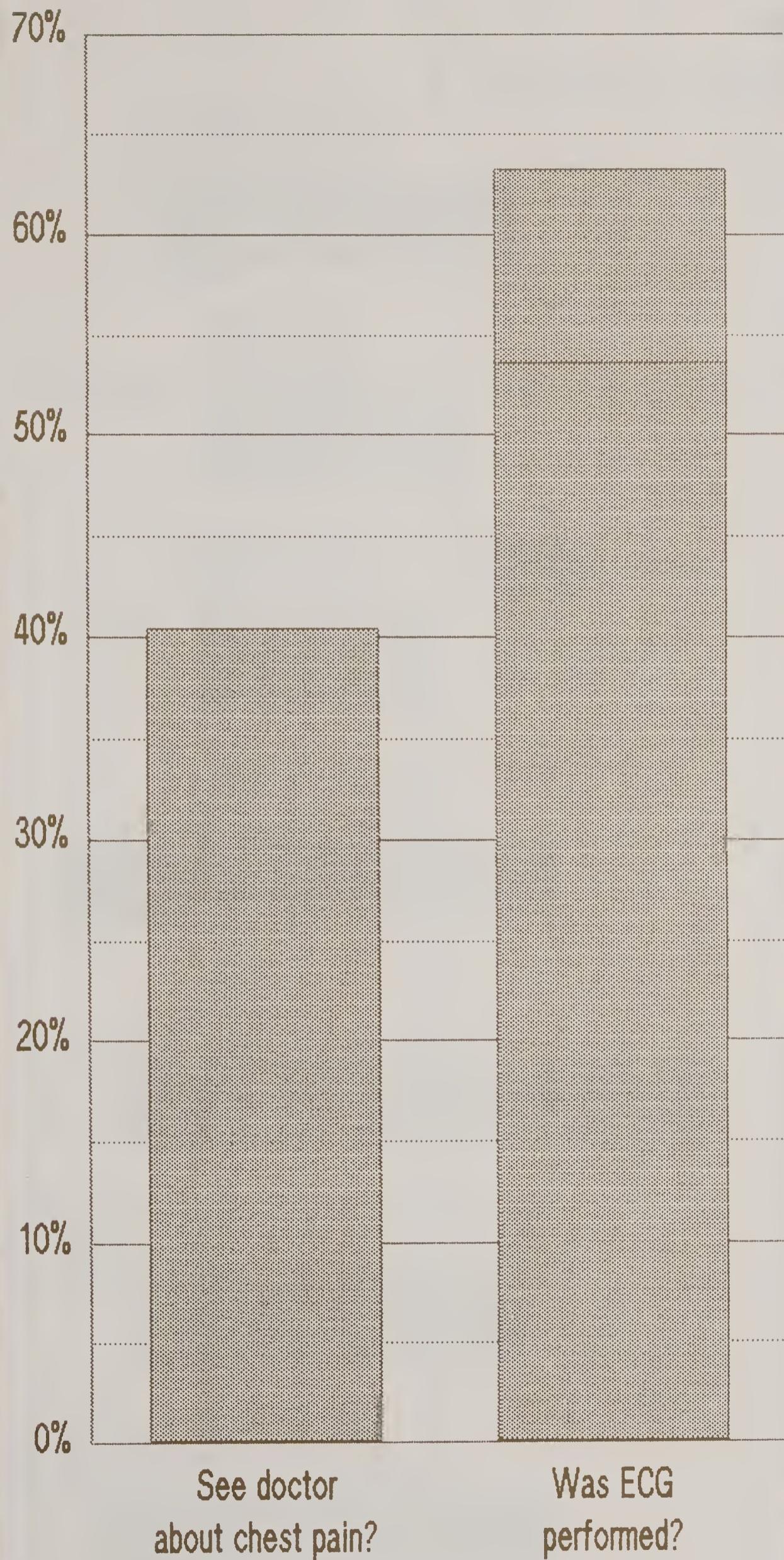
### Age-Sex Specific Rates for Chest Pain

Both sexes report chest pain in equal proportions, however there is variation by age.



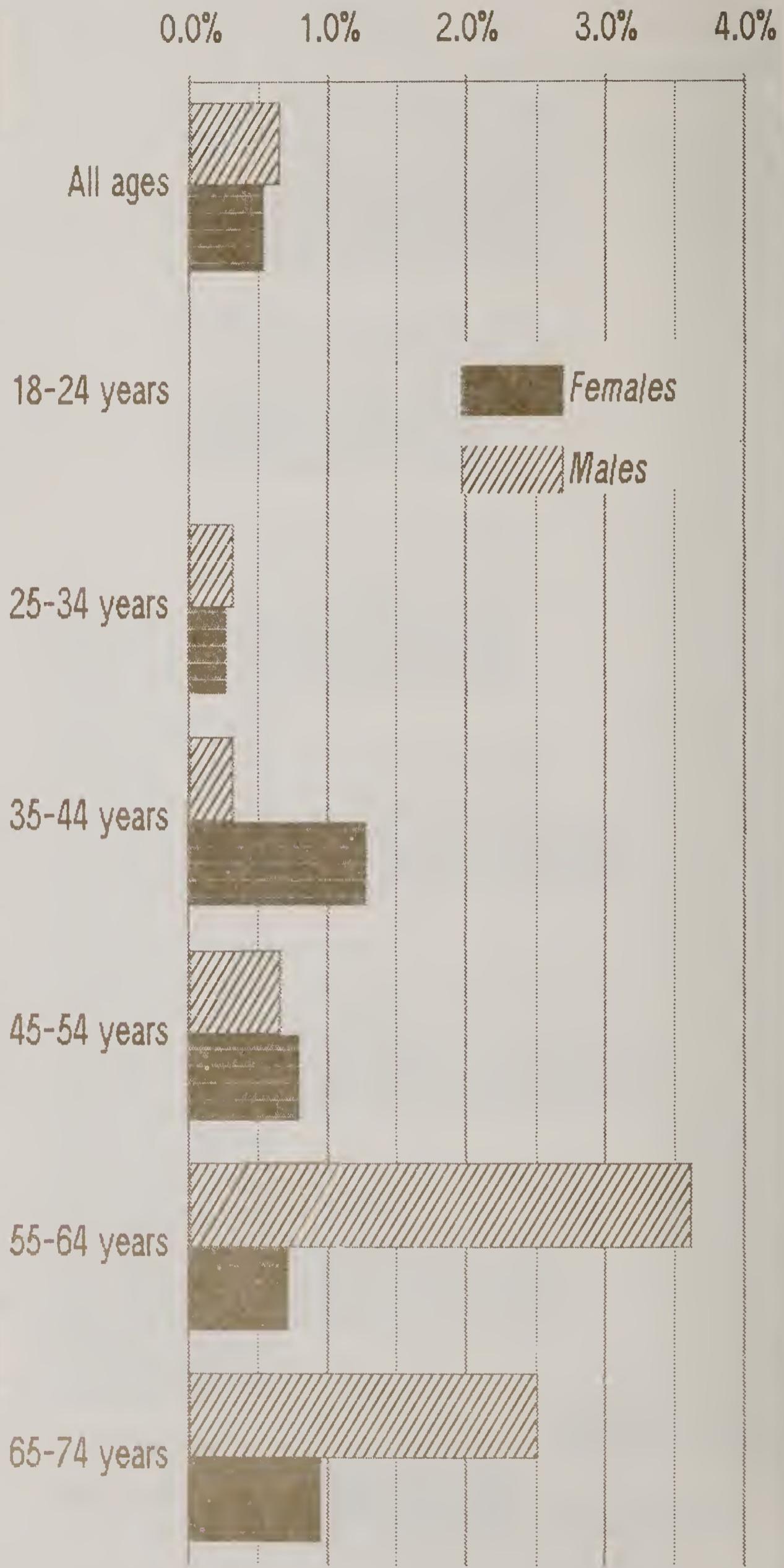
### Responses to Chest Pain

Of those persons reporting chest pain 60% had not seen a physician for the pain. Of those persons who saw a physician for the chest pain 36% did not have an ECG.



**Age-Sex Specific Rates for Diagnosis of Emphysema**

Relatively few individuals had emphysema, but of those, males were affected most frequently.



### Age-Sex Specific Rates for Diagnosis of Bronchitis

Bronchitis is most common in females. Especially vulnerable ages for females are 45-54.



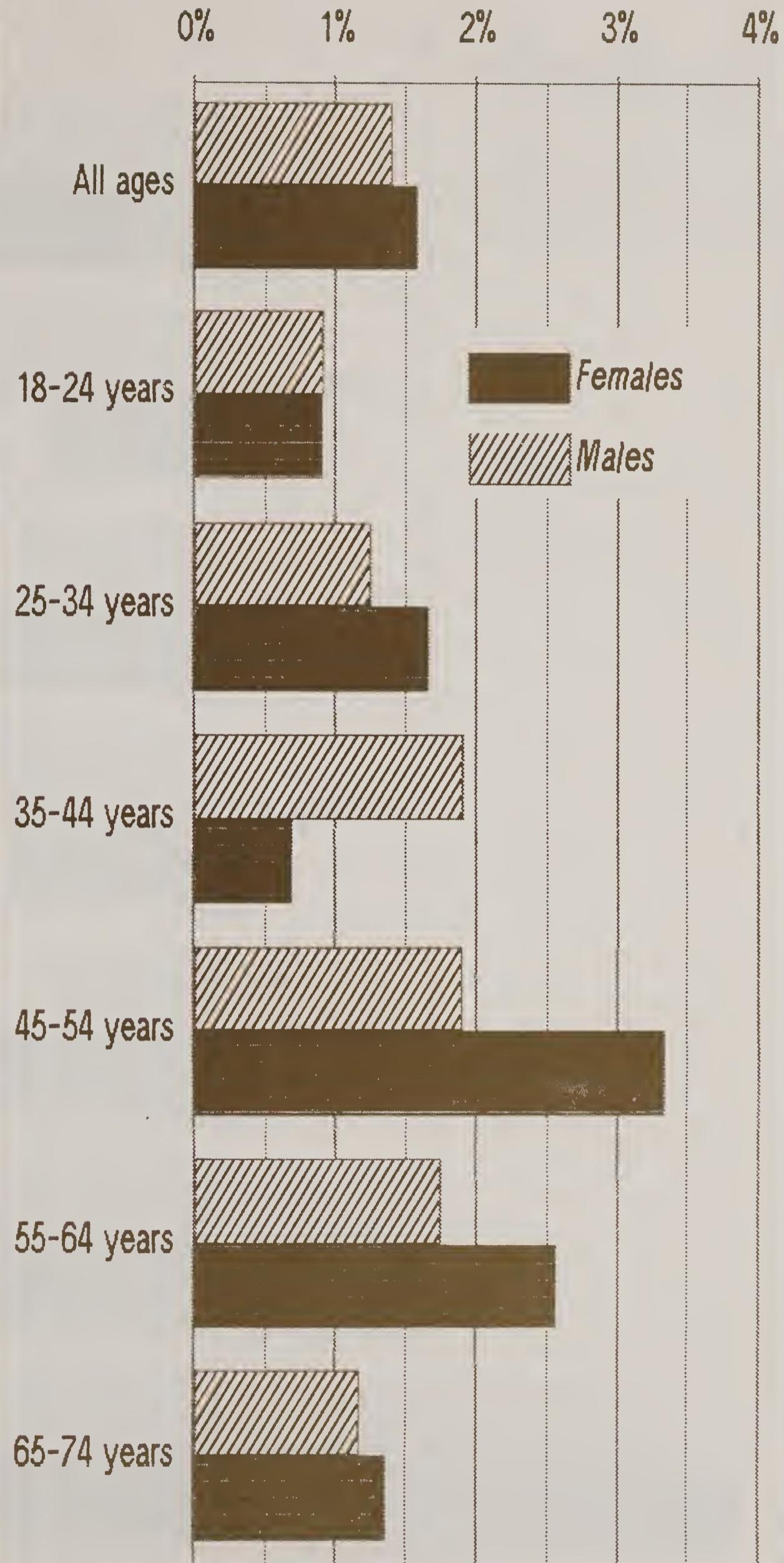
**Age-Sex Specific Rates for Diagnosis of Rheumatic Heart Disease**

Females at all ages are more likely to report a history of rheumatic heart disease than males except between the ages of 55-64.



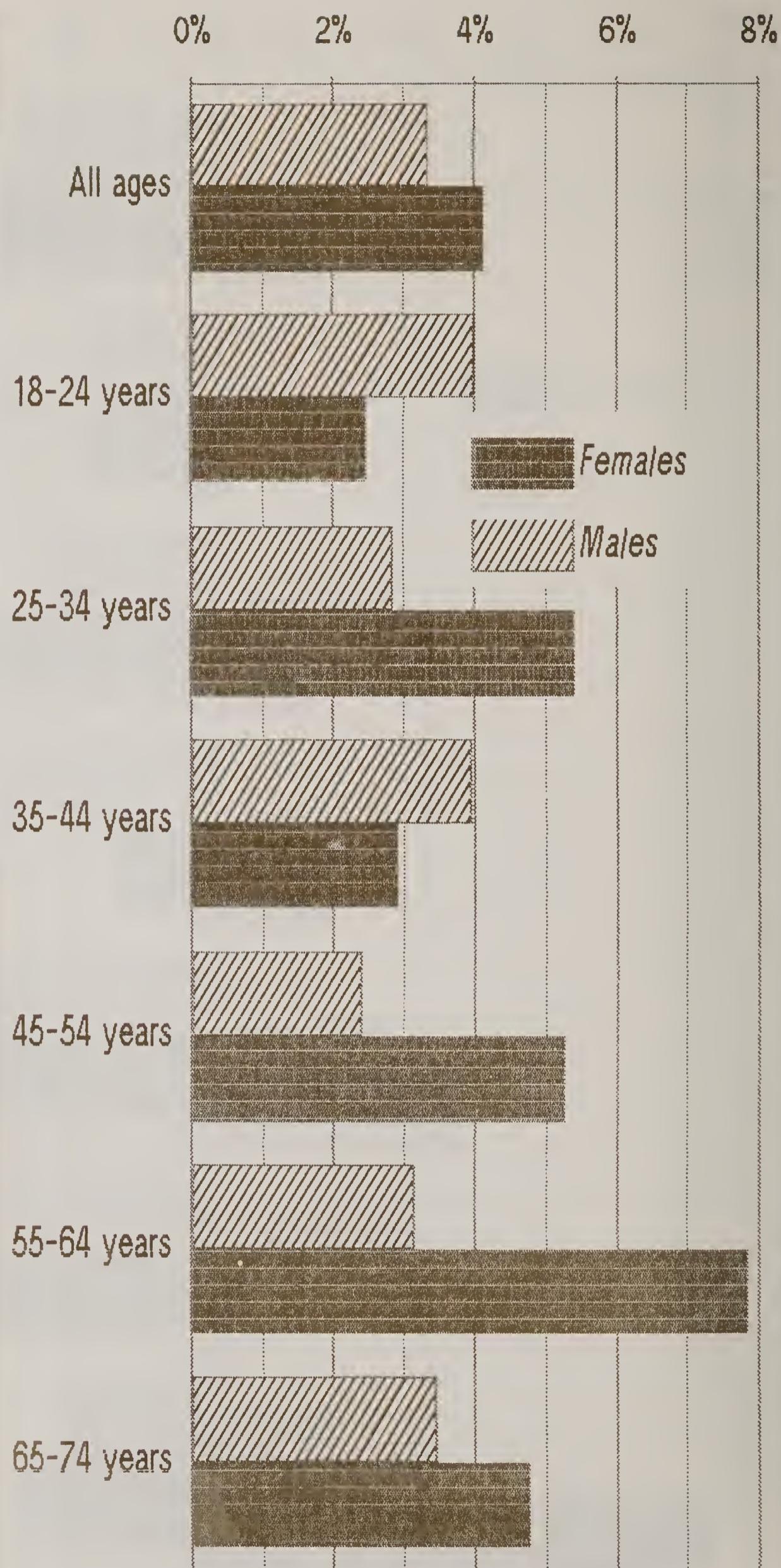
### Age-Sex Specific Rates for Diagnosis of Rheumatic Fever

Males have higher rates of rheumatic fever between the ages of 18-24 and 35-44, otherwise females have higher rates.



### Age-Sex Specific Rates for Diagnosis of Heart Murmur

Heart murmur is more common among females. Between ages 55-64 the rates are dramatically higher for females.



### Age-Sex Specific Rates for Diagnosis of Heart Failure

Heart failure rates are low for both sexes until age 45, then it increases markedly.



**Age-Sex Specific Rates for Diagnosis of Heart Attack**

Males have heart attacks more frequently than do females.



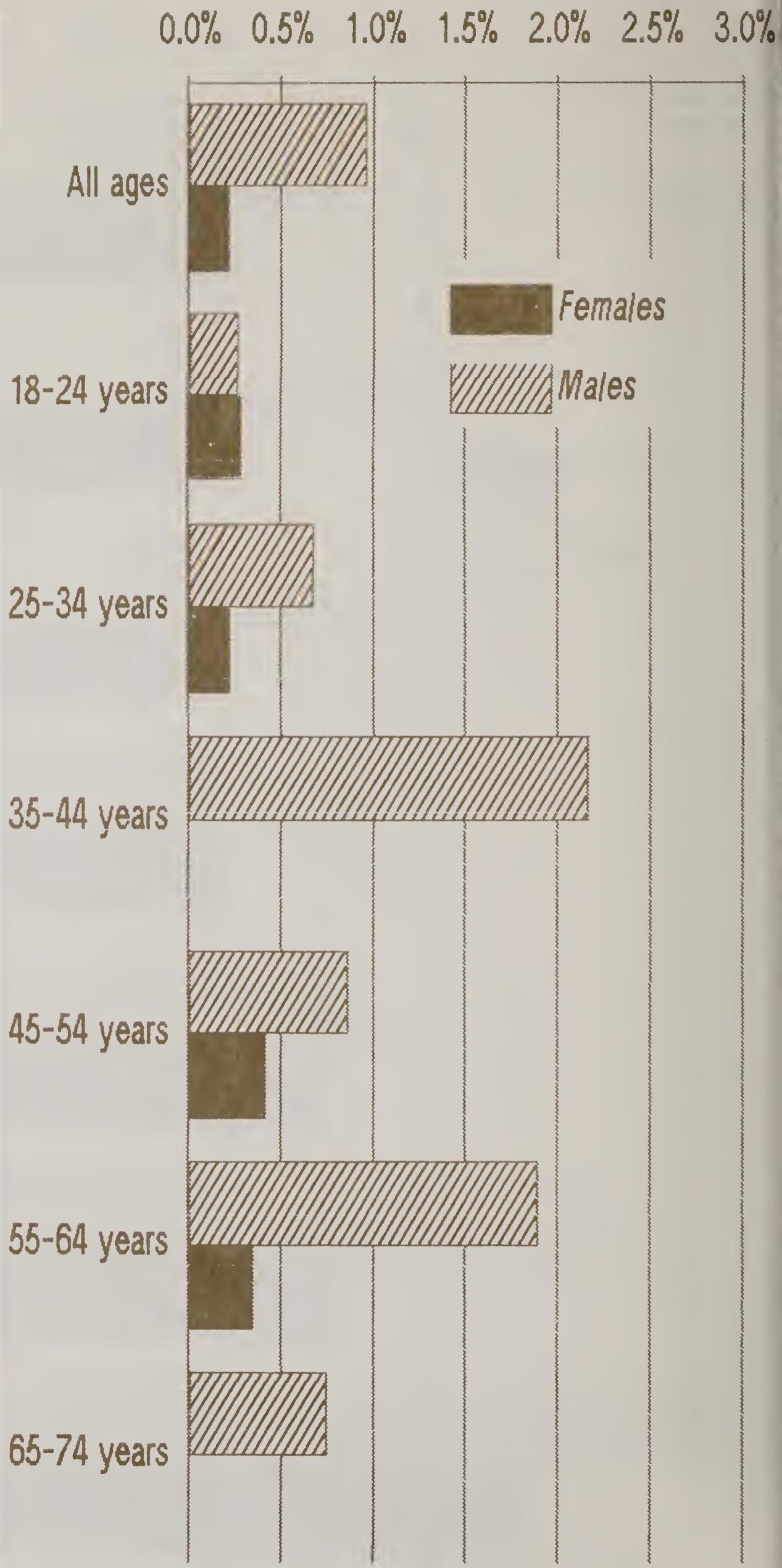
### Age-Sex Specific Rates for Diagnosis of Kidney Problems

At every age level females have kidney disease more often than do males.



### Age-Sex Specific Rates for Diagnosis of Cirrhosis

Between ages 18-24 males and females have similar rates of cirrhosis, but thereafter male rates are much higher.



### Age-Sex Specific Rates for Diagnosis of Hepatitis

Males appear to be much more susceptible to hepatitis.



### Age-Sex Specific Rates for Diagnosis of Yellow Jaundice

Yellow jaundice rates, overall, are slightly higher for females, but there is some reversal to this trend between ages 45-64.



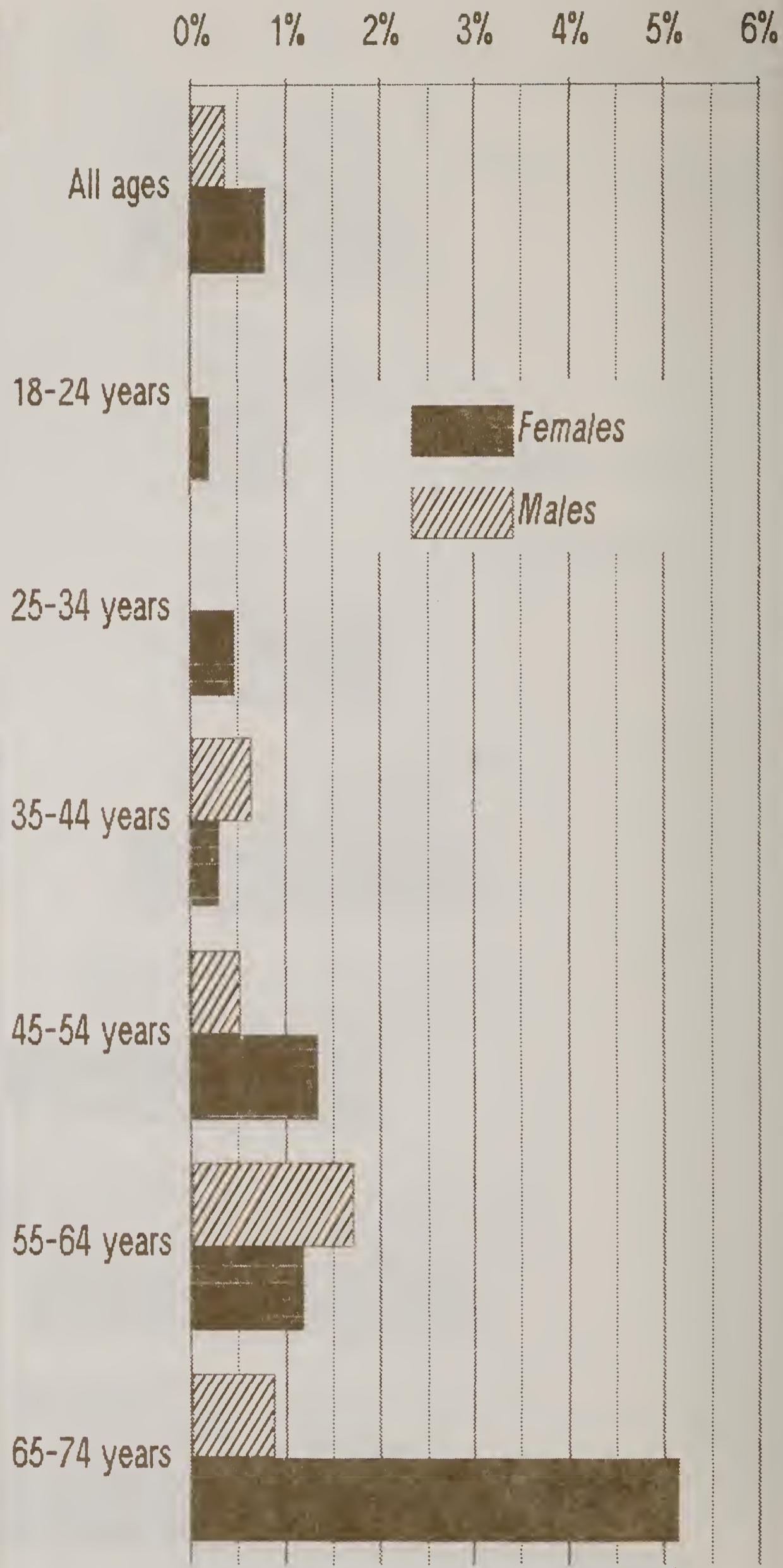
**Age-Sex Specific Rates for Diagnosis of Stroke**

Stroke rates vary by age and sex; females are more vulnerable at younger ages and males after the age of 55.



**Age-Sex Specific Rates for Diagnosis of Glaucoma**

Females are at high risk for glaucoma after age 65.



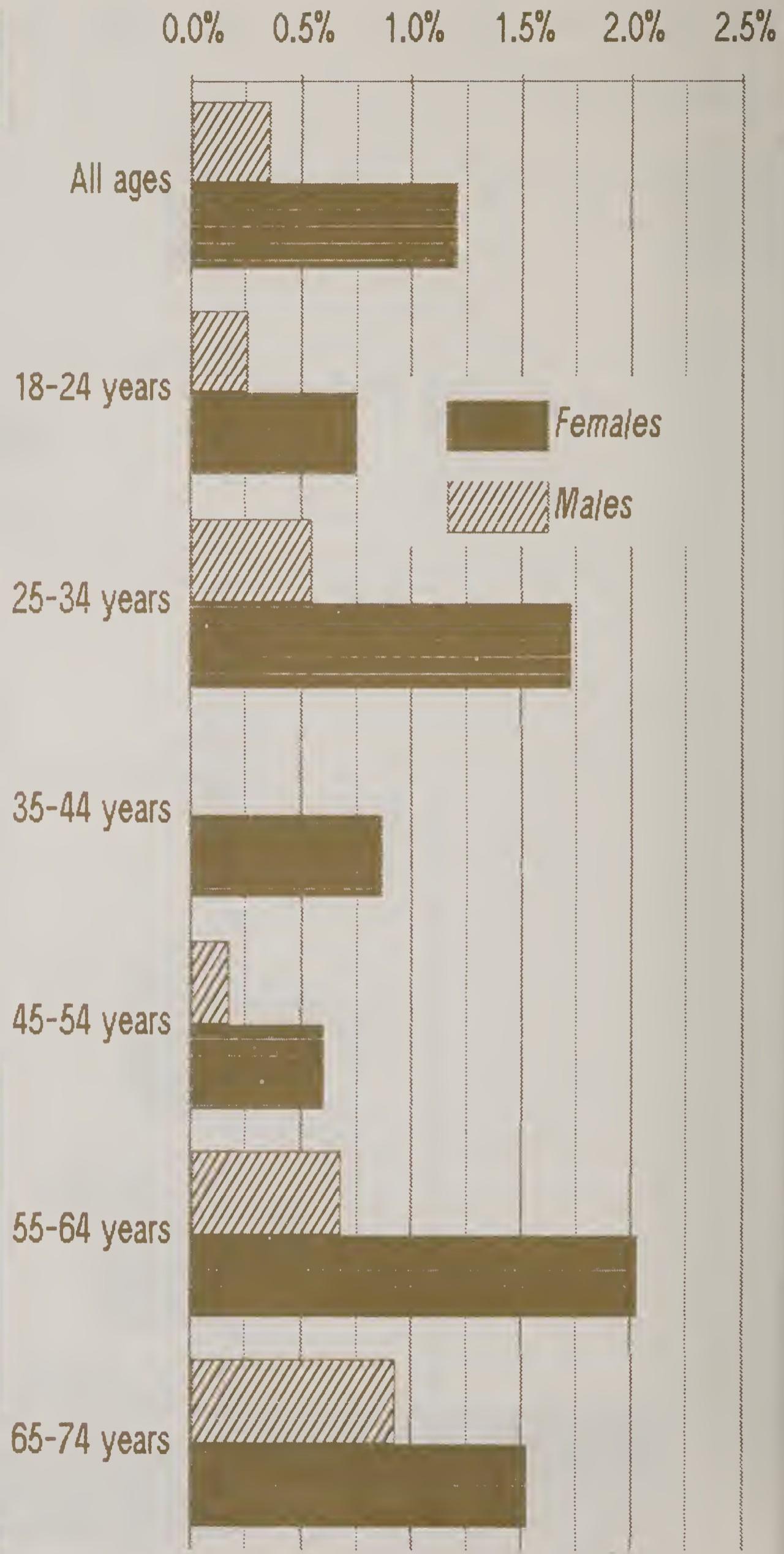
### Age-Sex Specific Rates for Diagnosis of Cataracts

Cataracts, overall, occur at nearly similar frequencies for both sexes, but there are variations at specific age groupings.



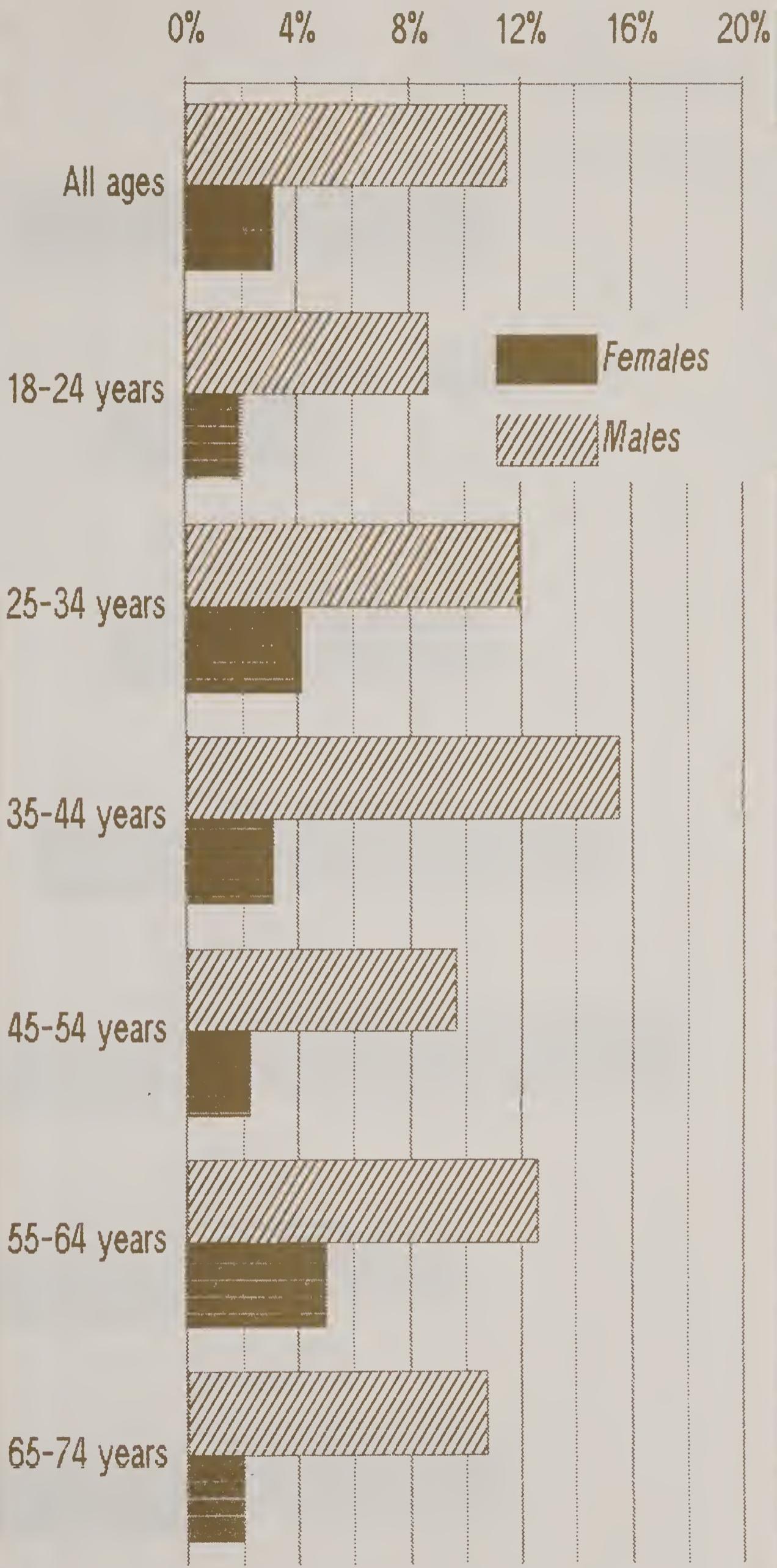
### Age-Sex Specific Rates for Diagnosis of Strabismus

Females have strabismus much more frequently than do males.



### Age-Sex Specific Rates for Diagnosis of Eye Injury

Eye injuries are a relatively common occurrence among males.



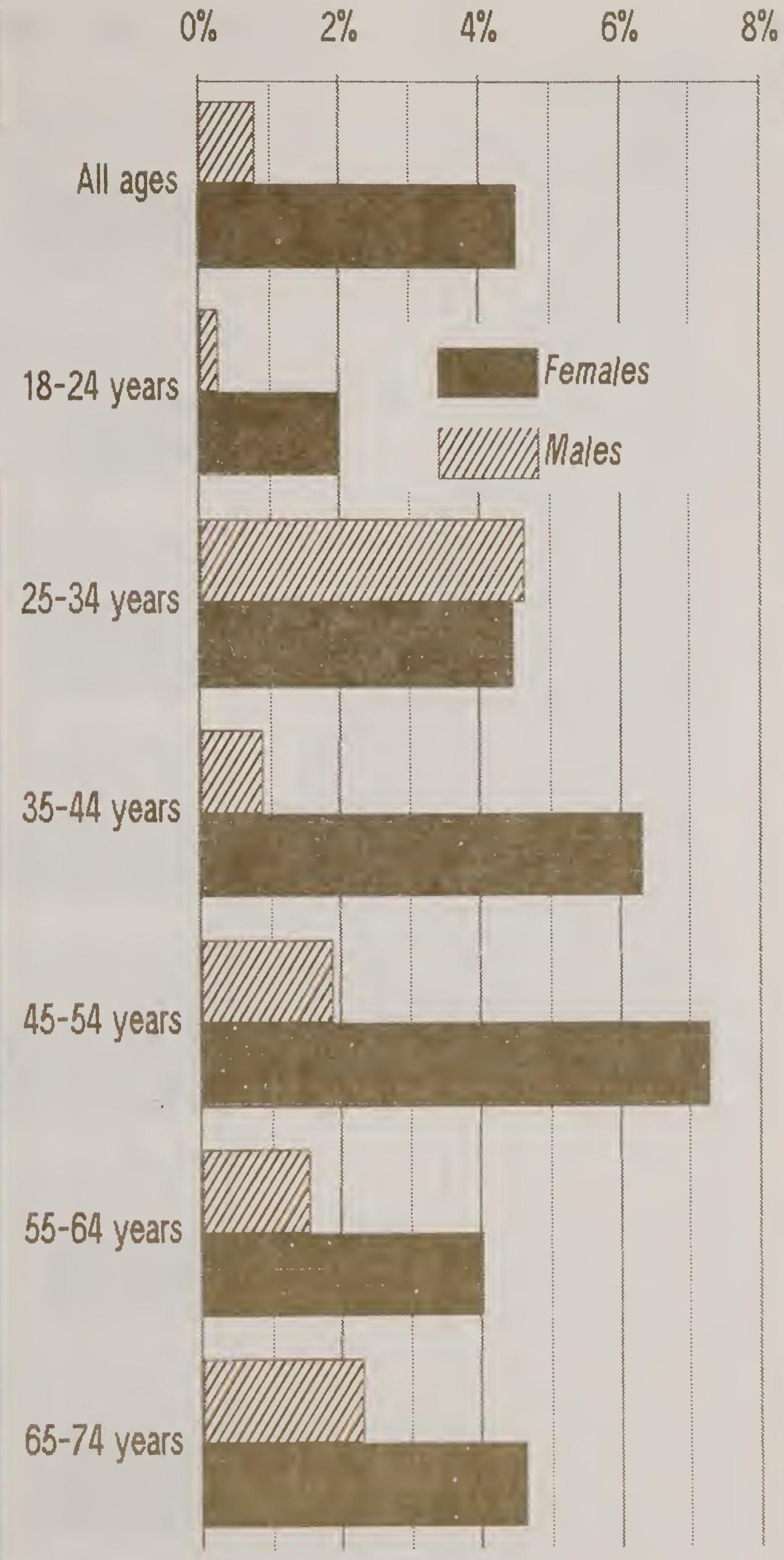
**Age-Sex Specific Rates for Diagnosis of Goiter**

Females are more likely to have goiter problems than are males.



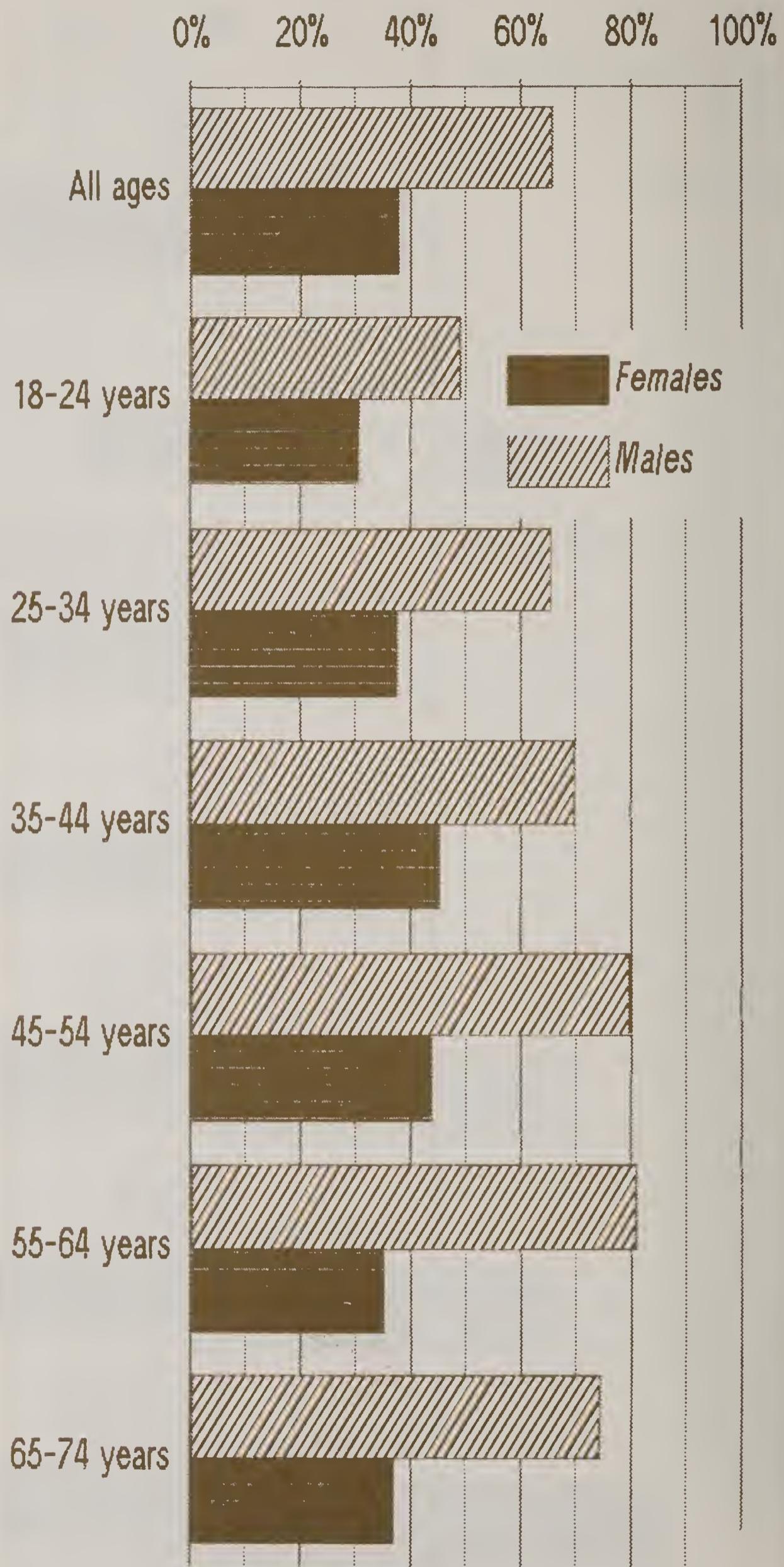
### Age-Sex Specific Rates for Diagnosis of Thyroid Disease

Thyroid disease is more common in females.



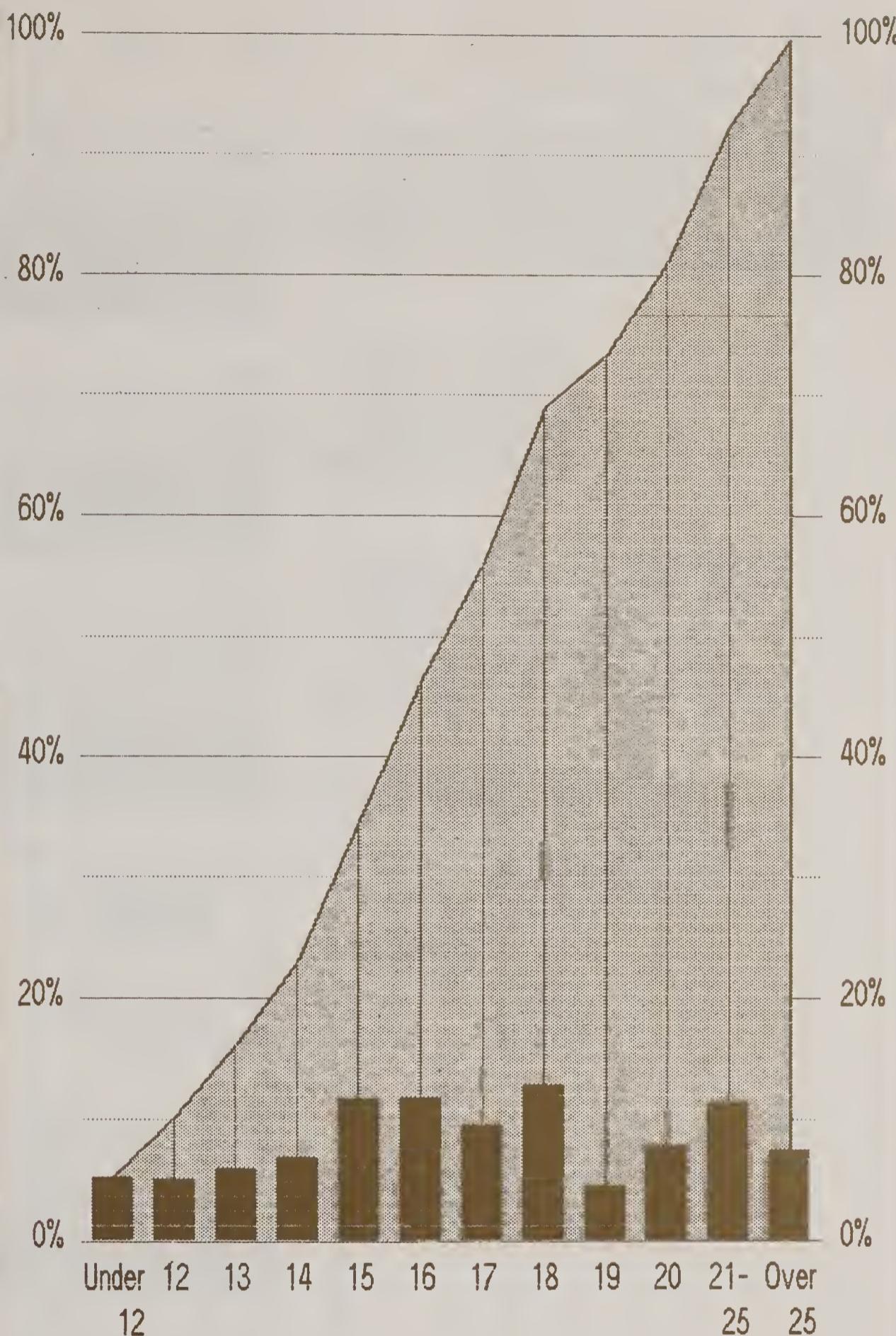
**Age-Sex Specific Rates for History of Tobacco Use**

Approximately 50% of adults are or have been smokers. The number of male smokers is much larger than the number of female smokers.



**Age and Cumulative Age at Which Respondent Started Smoking**

Almost 70% of respondents started smoking by age 18. Over 20% started smoking by age 14.



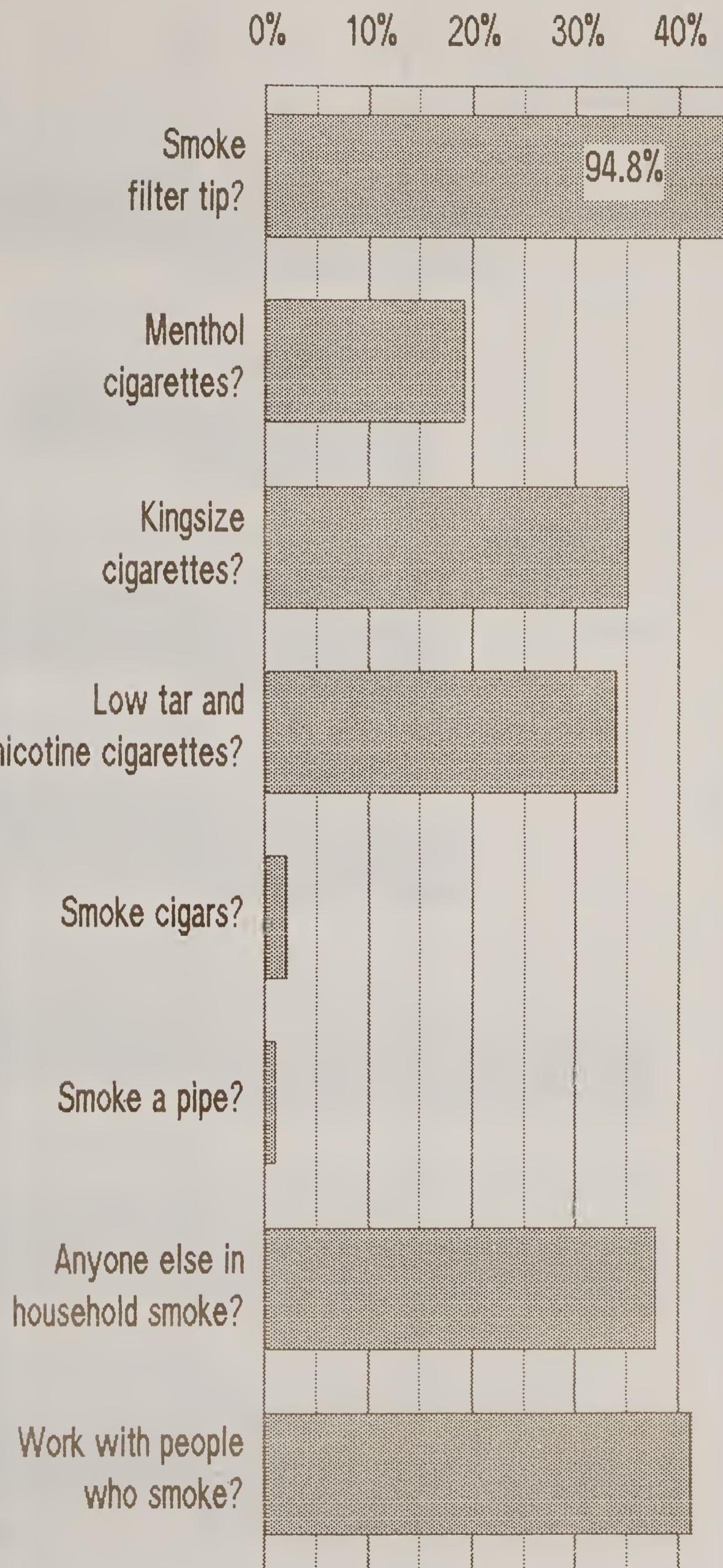
### Age-Sex Specific Rates for Current Tobacco Use

At all age levels male smokers outnumber female smokers. After age 45 the number of smokers declines among both sexes.



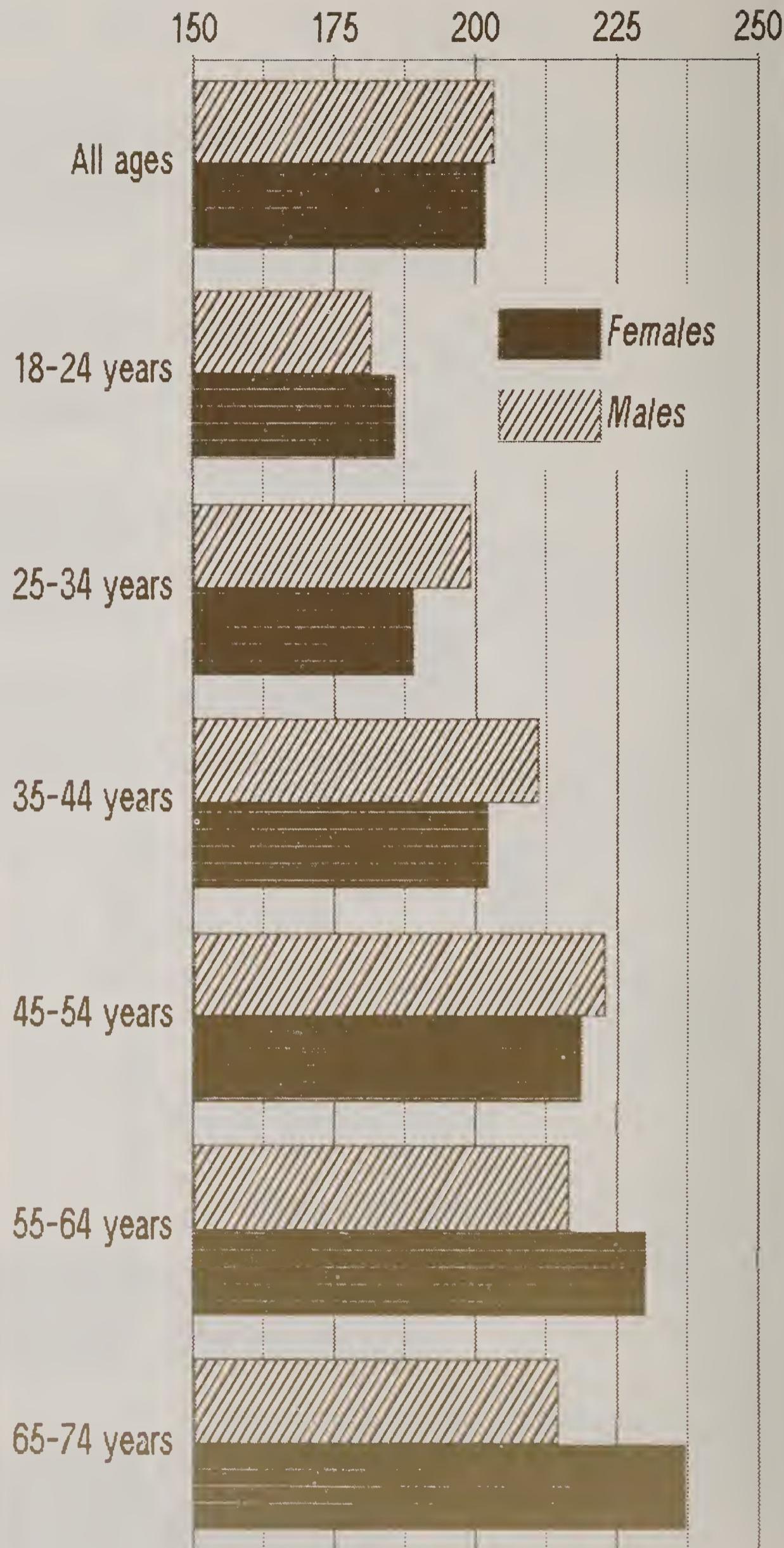
**Aspects of Tobacco Use**

Over 90% of smokers smoke filter tips. Low tar and nicotine cigarettes are favored by almost 35% of smokers.



**Age-Sex Specific Mean Serum Cholesterol Levels**

Mean serum cholesterol levels do not vary markedly by age or sex.



### Age-Sex Specific Rates for Vision Impairment

Females are more likely to have vision impairment, however the rates between males and females are not substantially different.



**Age-Sex Specific Rates for Hearing Impairment**

Males are more likely to have hearing impairment.



## CHAPTER 4

### Mental Health Factors

Depression is the only mental health condition examined in this document. The findings support previous knowledge regarding incidence rates of mental disorders among Mexican Americans; i.e. Hispanics have lower rates than other ethnic or racial groups. Symptoms reported most frequently should be of interest to many readers.

Depression was measured by two different instruments in The HHANES study, The National Institute of Mental Health Diagnostic Interview Schedule (DIS) and the Center for Epidemiologic Studies Depression Scale (CES-D). Charts in this manuscript are derived from data collected from both scales. The DIS scale adheres closely to criteria established in The Diagnostic and Statistical manual of Mental Disorders. The CES-D scale, a less rigorous instrument, suggests a depression incidence of 13% in contrast to the 8% figure from the DIS scale.

### Age-sex Specific Mean Scores for Depression Scale

The incidence rate of depression is higher for females, and it remains almost constant through the age levels.



**CESD Mean Scores by Years of Education**

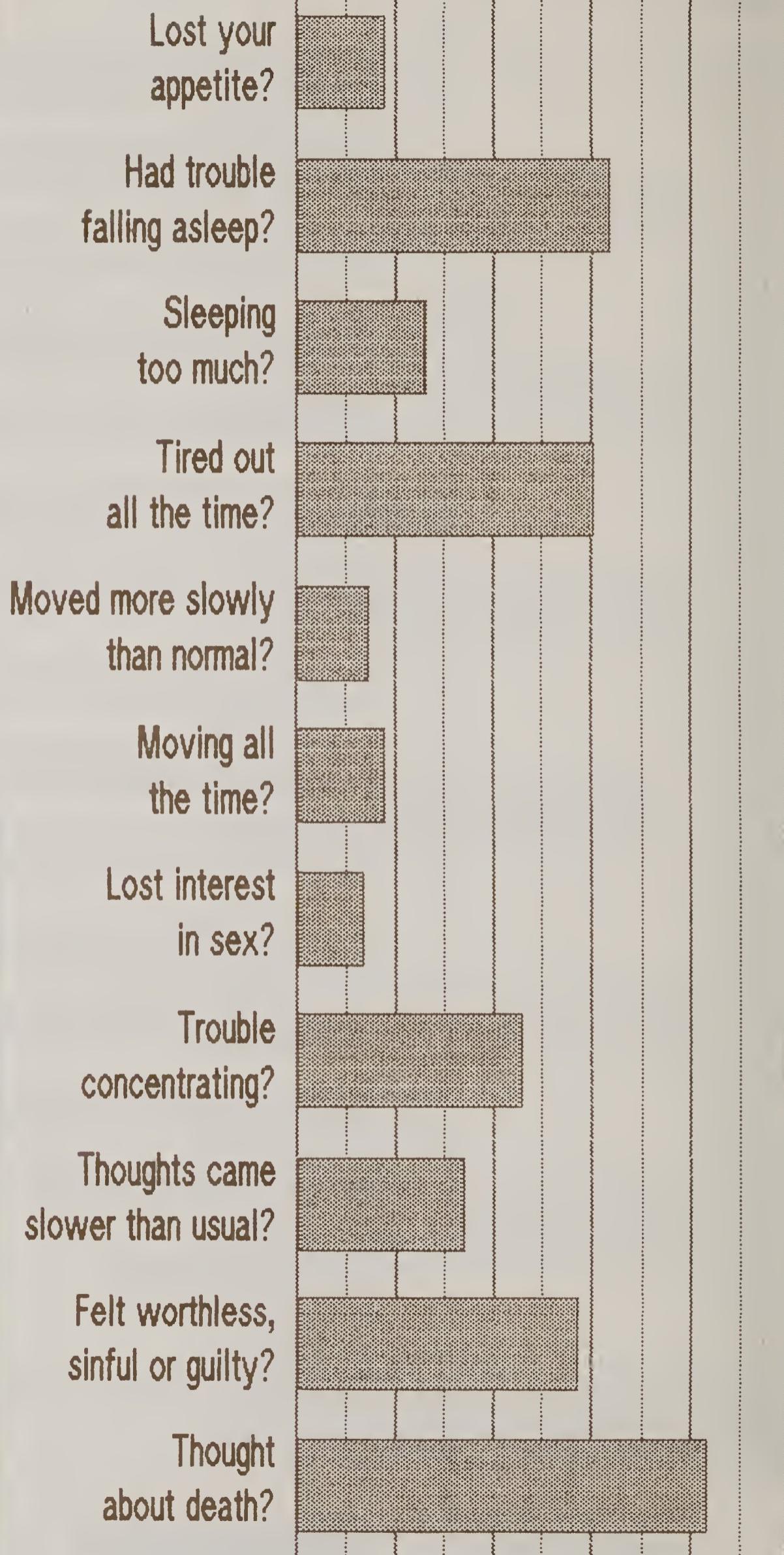
Depression scores were negatively related to number of years of formal education.



0% 5% 10% 15% 20% 25%

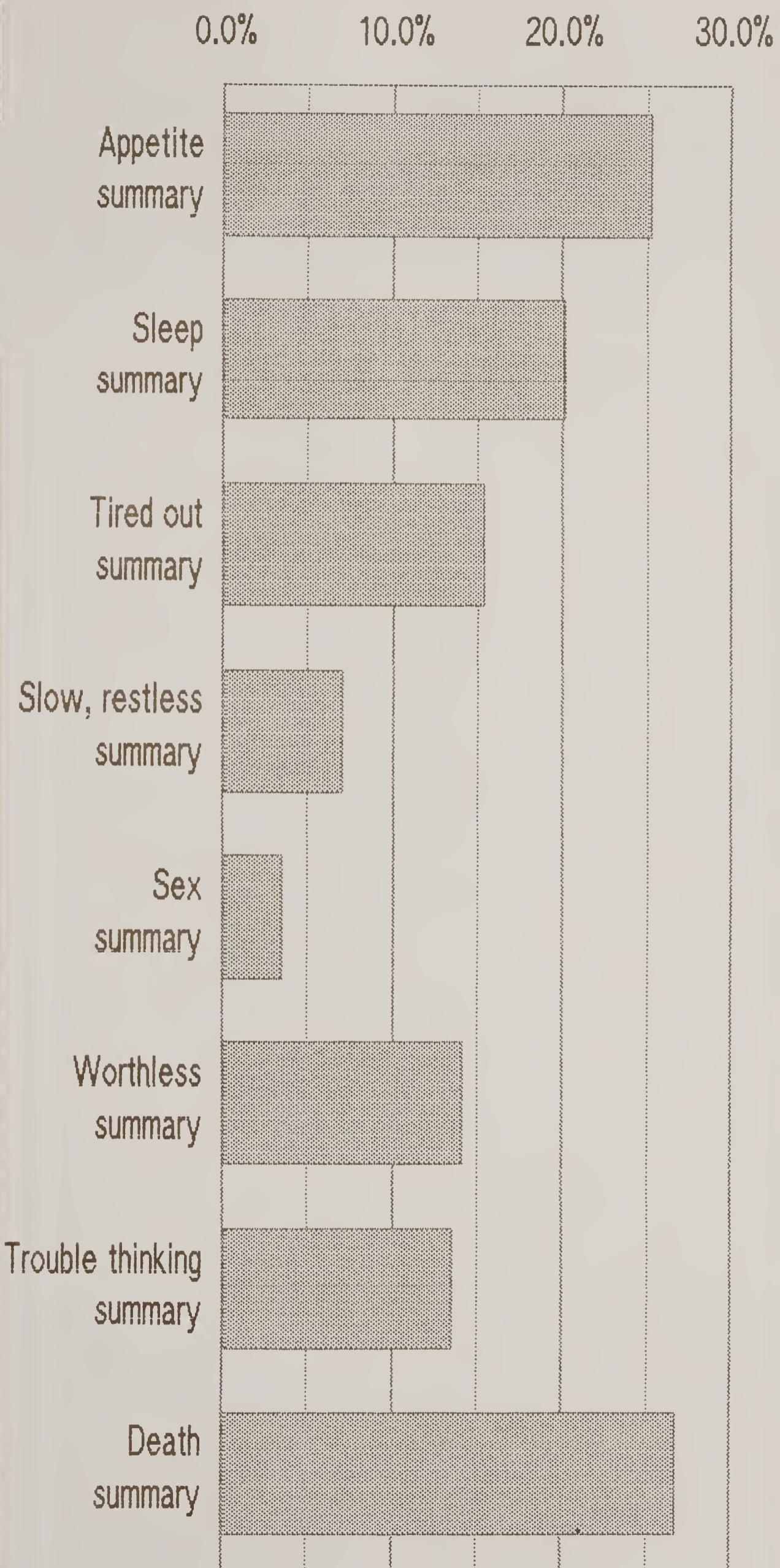
### Summary Items from CES-D Scale

The most frequently reported depression symptoms from this scale were appetite changes, sleep disturbance and thoughts of death.



### Summary of DIS Scale

The most frequently reported symptoms from the DIS scale were similar to those from the CES-D scale.





## **CHAPTER 5**

### **Reproduction and Fertility Factors**

The extent to which birth control practices are utilized will prove interesting to many of the readers of this document. Some-what startling is the failure to follow generally accepted standards for primary prevention regarding two common female illnesses. This omission, however, is apparent among males and females in other areas of health care practices. The number of respondents who have used birth control pills and the number who have had a tubal ligation may come as a surprise to some persons.

### Age and Cumulative Age and Menarche

By age 13 approximately 70% of respondents had begun menarche.

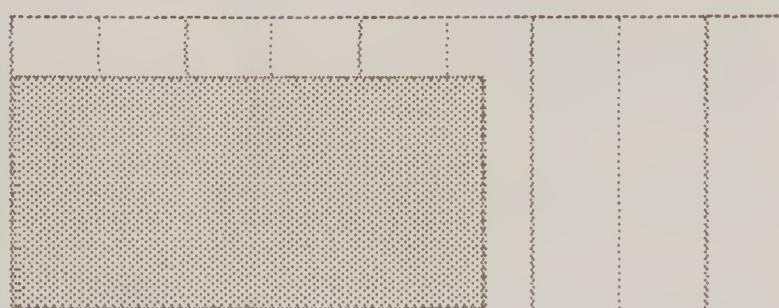


### Aspects of Fertility

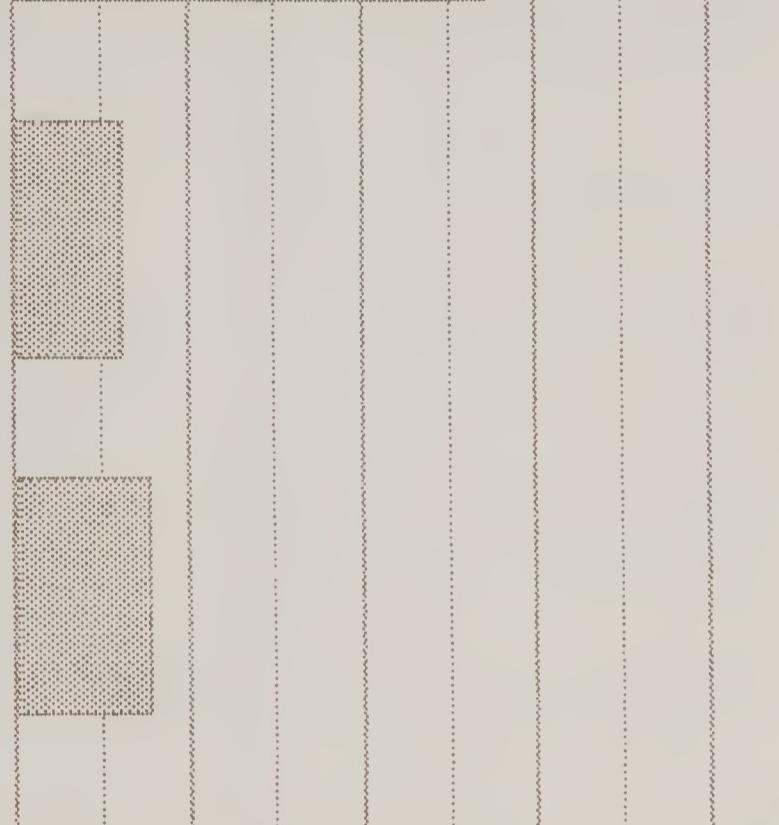
Over 50% of respondents have taken birth control pills. About 15% have had a tubal ligation. Almost 90% have been pregnant.

0% 20% 40% 60% 80%

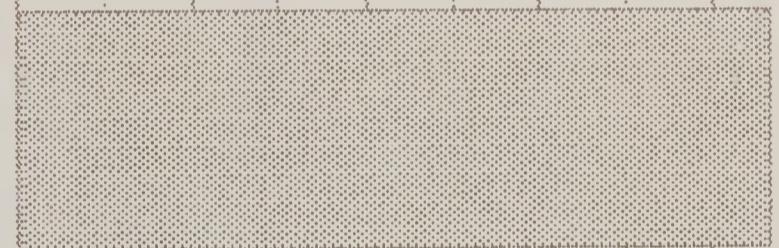
Ever taken  
birth control pills?



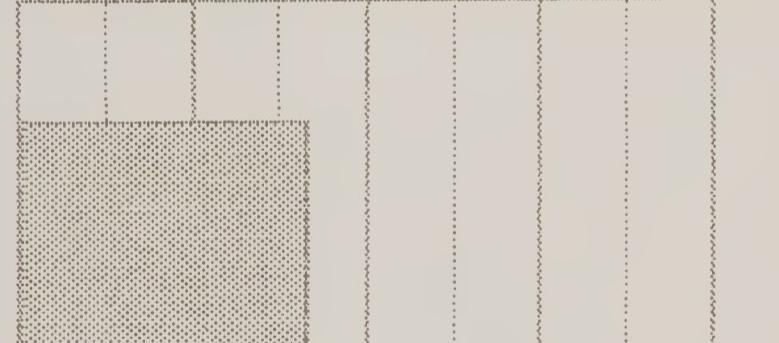
Ever had a  
hysterectomy?



Ever had a  
tubal ligation?



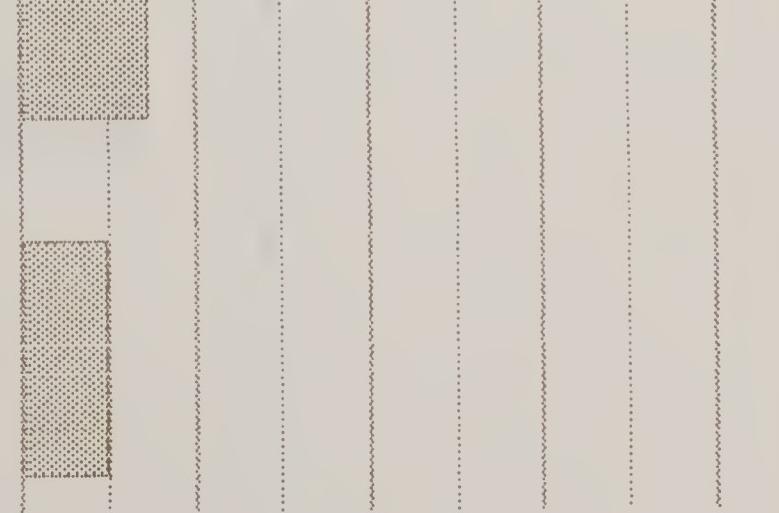
Ever been  
pregnant?



Ever had a  
miscarriage?



Ever had  
live birth  
less than 2500gms?

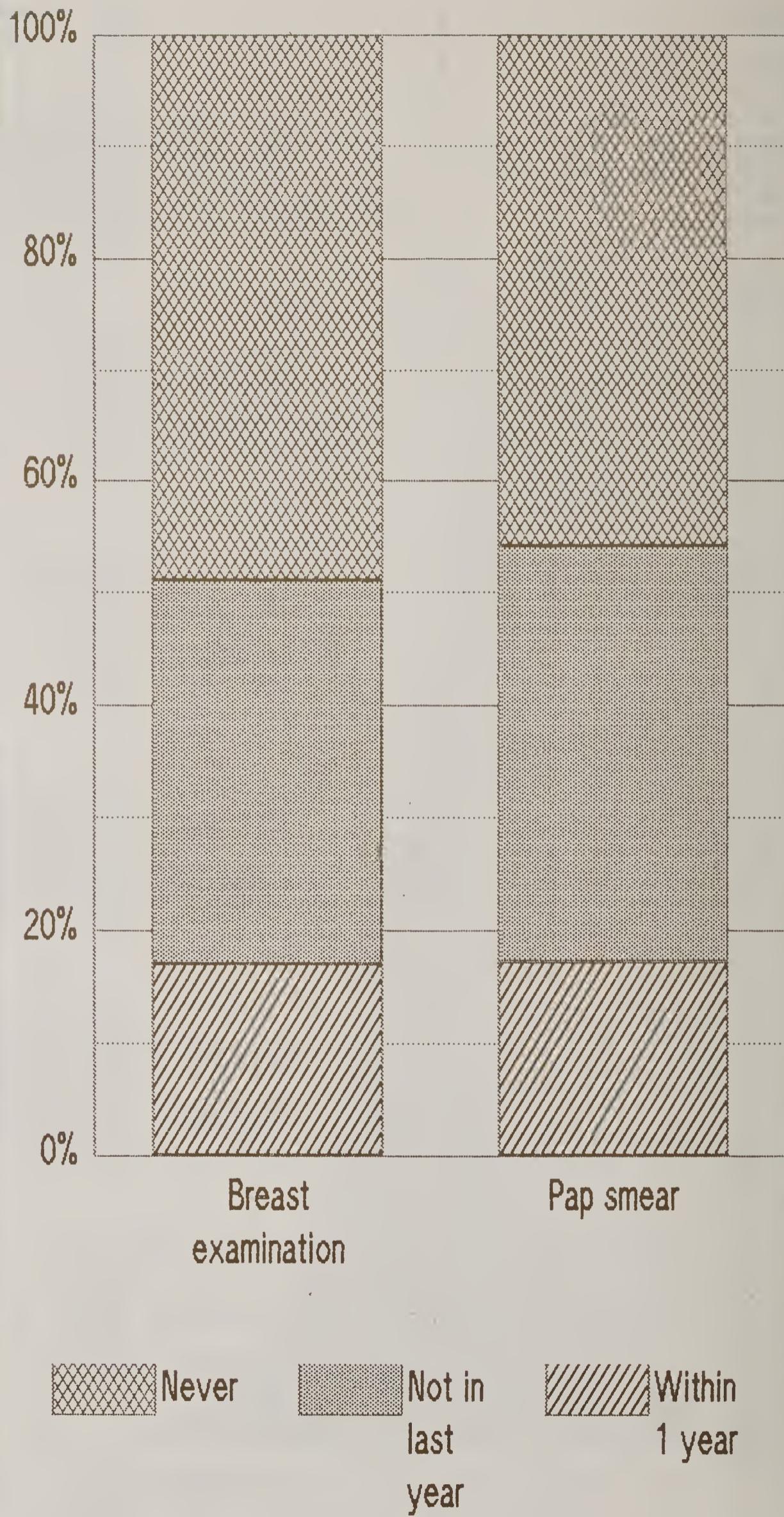


Ever had  
live birth  
with defect?

### 5.3

#### Time Since Last Pap Smear and Breast Examination

Approximately 40% of respondents have never had their breasts examined by a health professional. About the same percentage have never had a pap smear.



## CHAPTER 6

### Health Care Utilization

In 1983, family income for minorities was positively related to the frequency of physician and dental visits, but negatively related to the number of hospital discharges and the length of hospital stay. In 1978, an estimated 30 million people were without a regular source of medical care, and approximately half indicated "no doctor needed" as the primary reason.

Between 1976 and 1981, the annual number of visits to a physician's office decreased slightly from 2.78 to 2.59 according to data from the National Ambulatory Medical Care Survey.

The Hispanic Health and Nutrition Examination Survey indicated that fifty three percent of the Mexican American respondents reported that their usual source of health care was a private physician or clinic, five percent utilized an outpatient clinic and seven percent a Community Health Center.

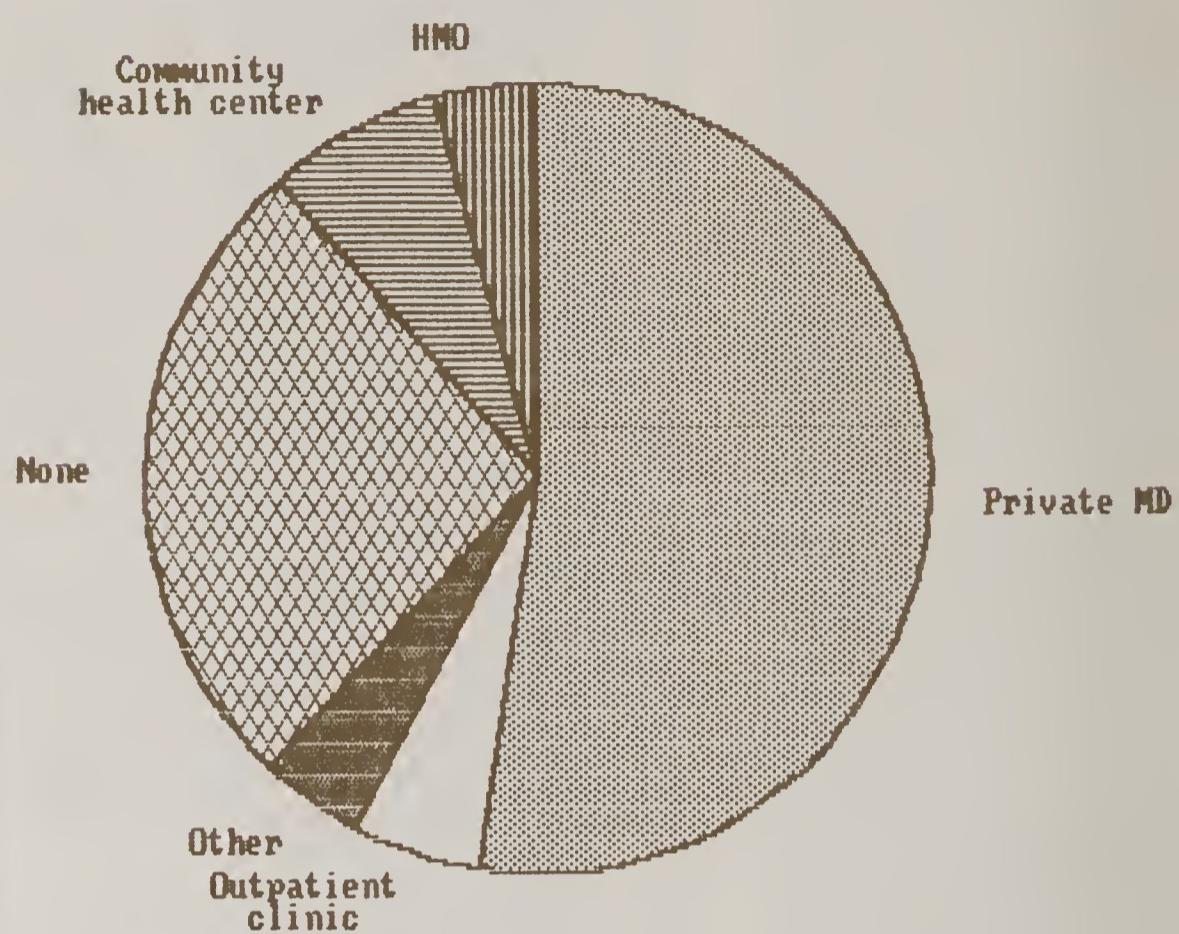
Mexican Americans indicated that of the factors effecting their non-use of health care, the two most frequently noted were cost and long periods of waiting.

It is important to note that nineteen percent of Mexican Americans have never had a routine physical examination and twenty-one percent had an examination five years ago. Also, nine percent were never examined by a dentist, and only seventeen percent saw one within the last five years.

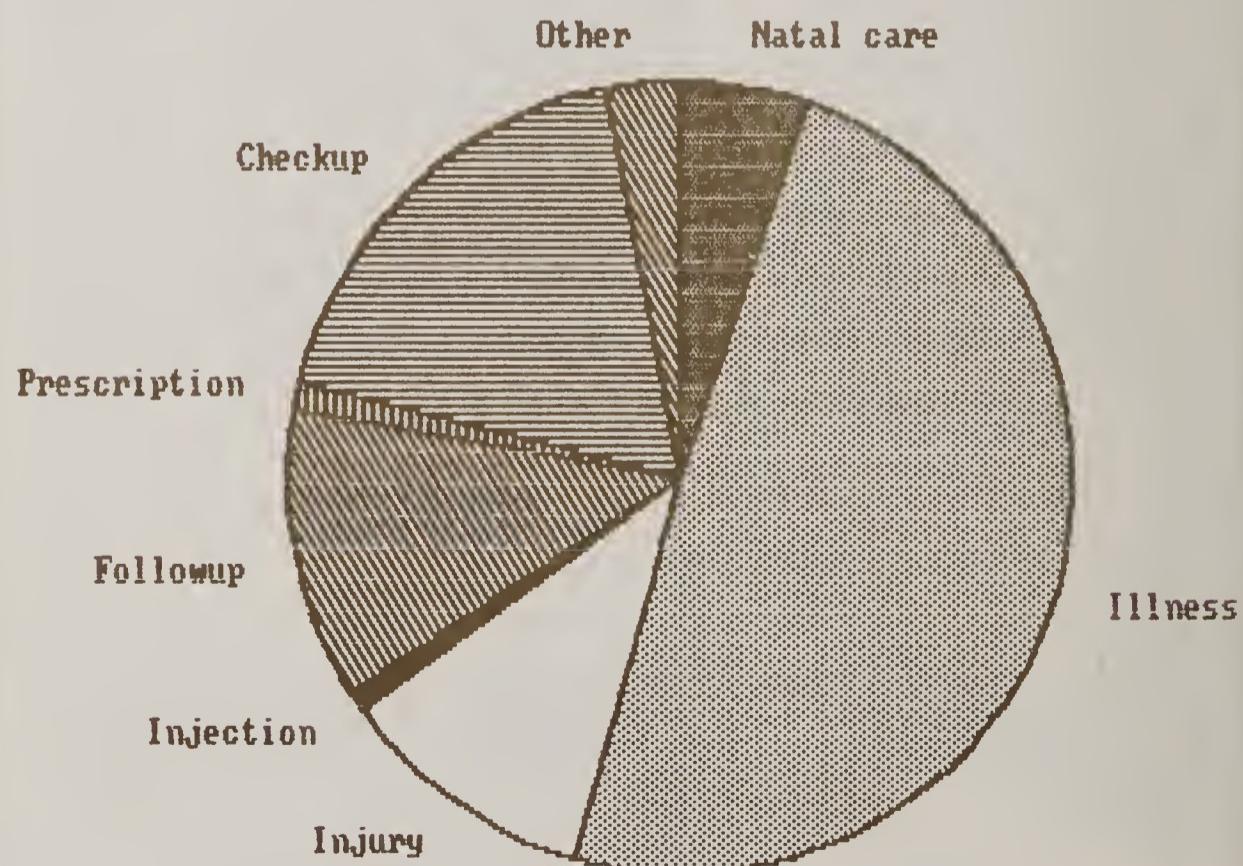
Mexican American females were admitted more frequently to a hospital than males.

**Health Care Utilization I****a.**

Fifty-three percent reported that their usual source of health care was a private physician or clinic.

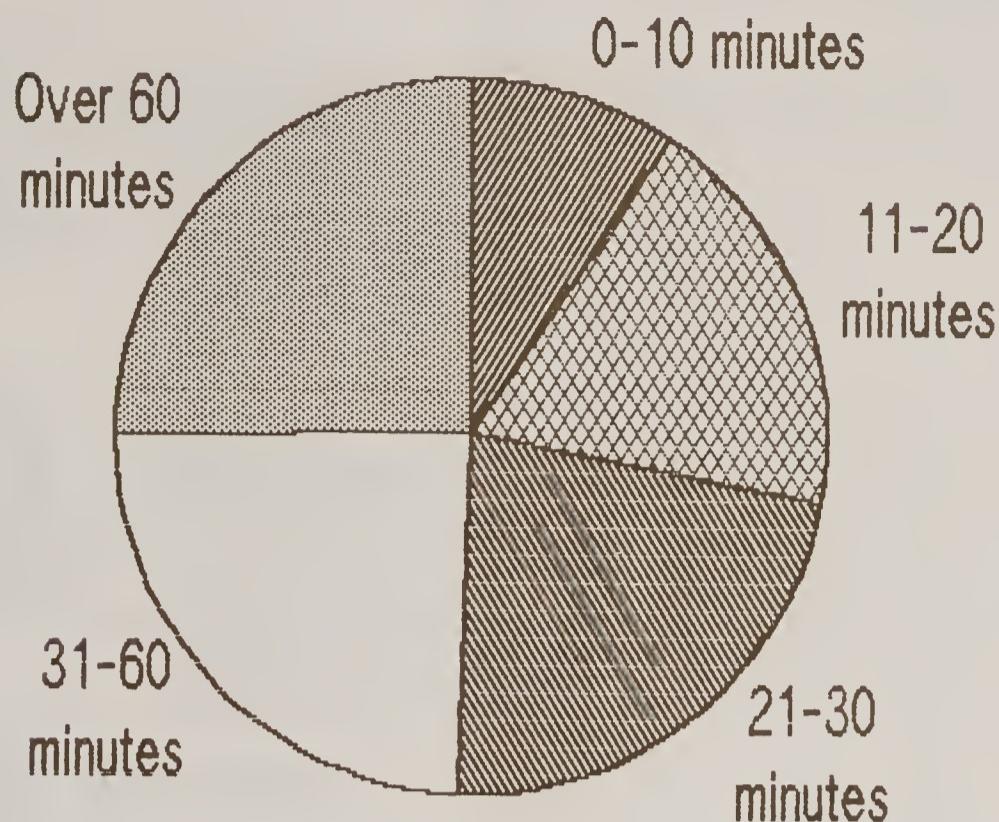
**Type of Usual Source of Health Care****b.**

Approximately 49 percent of the respondents reported that the purpose of their most recent visit to their usual source of health care was due to some illness.

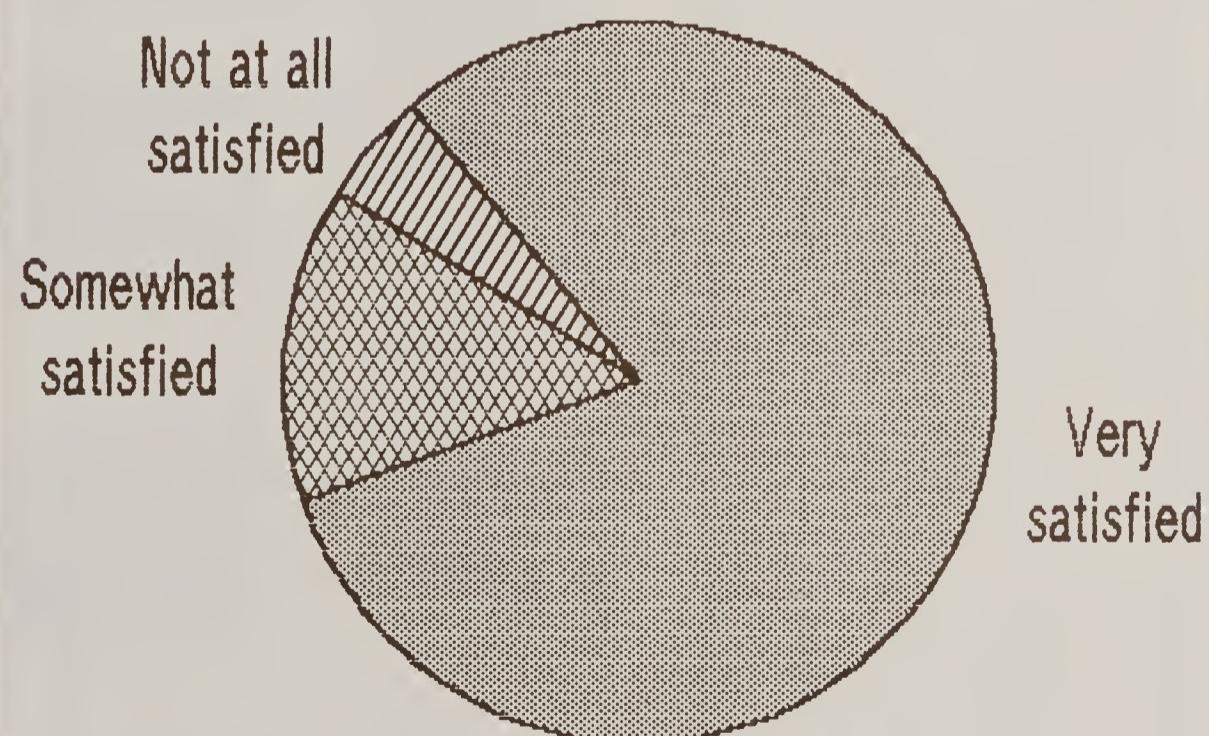
**Reason for Last Visit for Health Care**

**Health Care Utilization II****a.**

About half of the respondents indicated that it took thirty minutes or less to get to their usual source of health care.

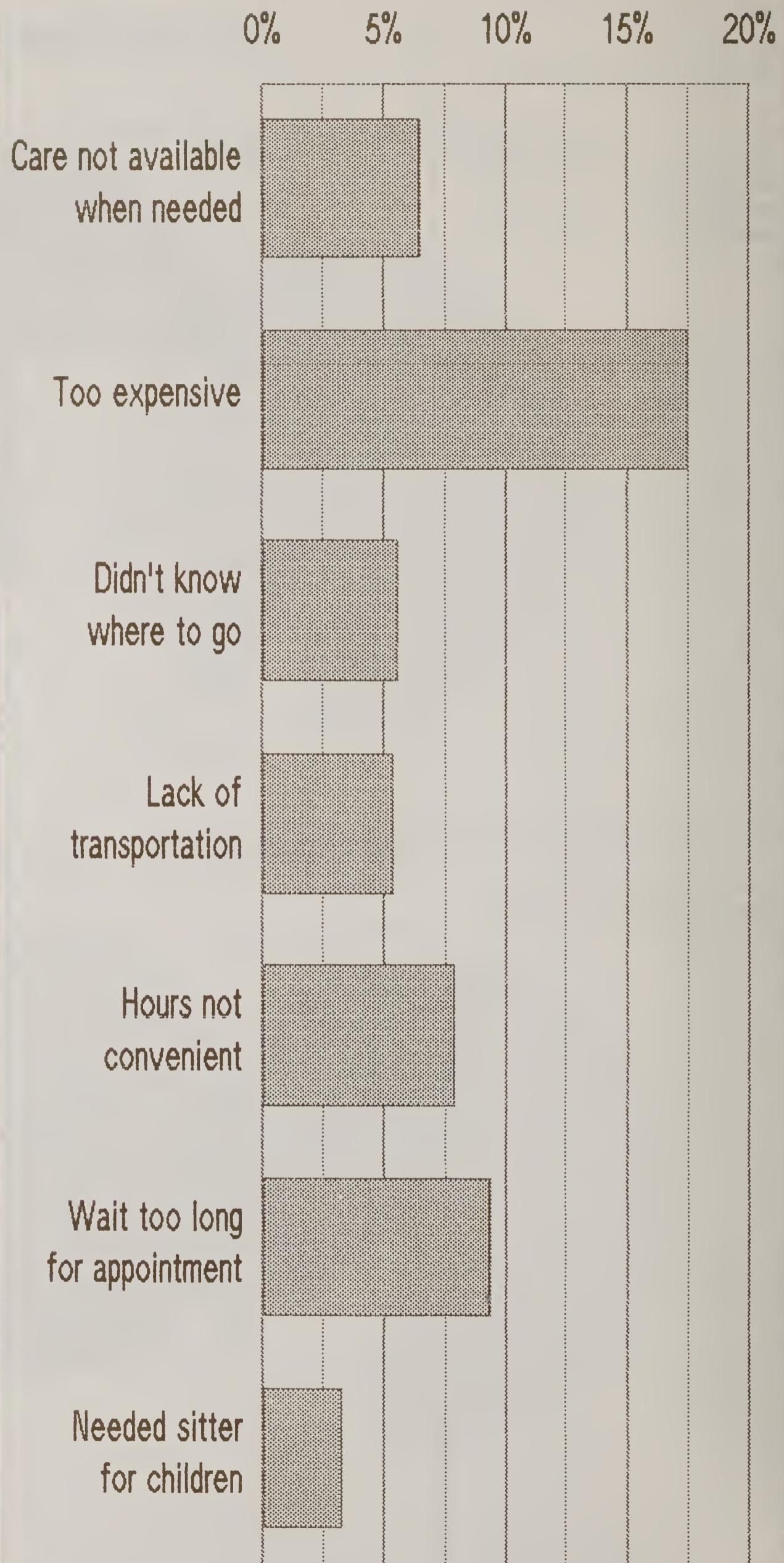
**Time to get to Usual Source of Health Care****b.**

About eighty-one percent were very satisfied with their health care.

**Satisfaction with Last Visit to Usual Source of Health Care**

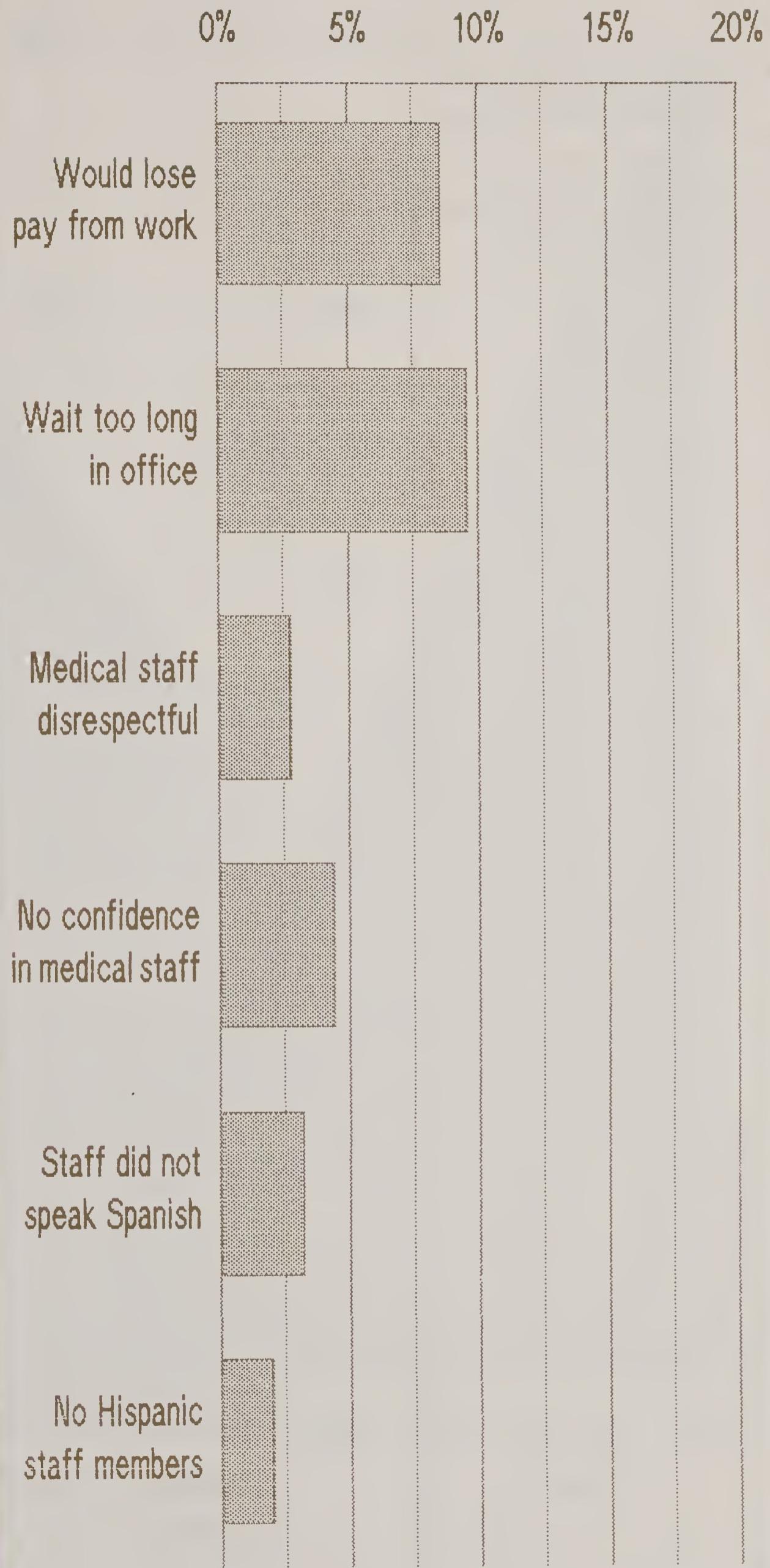
### Health Care Access Factors I

Cost was the major factor of dissatisfaction with health care.



## Health Care Access Factors II

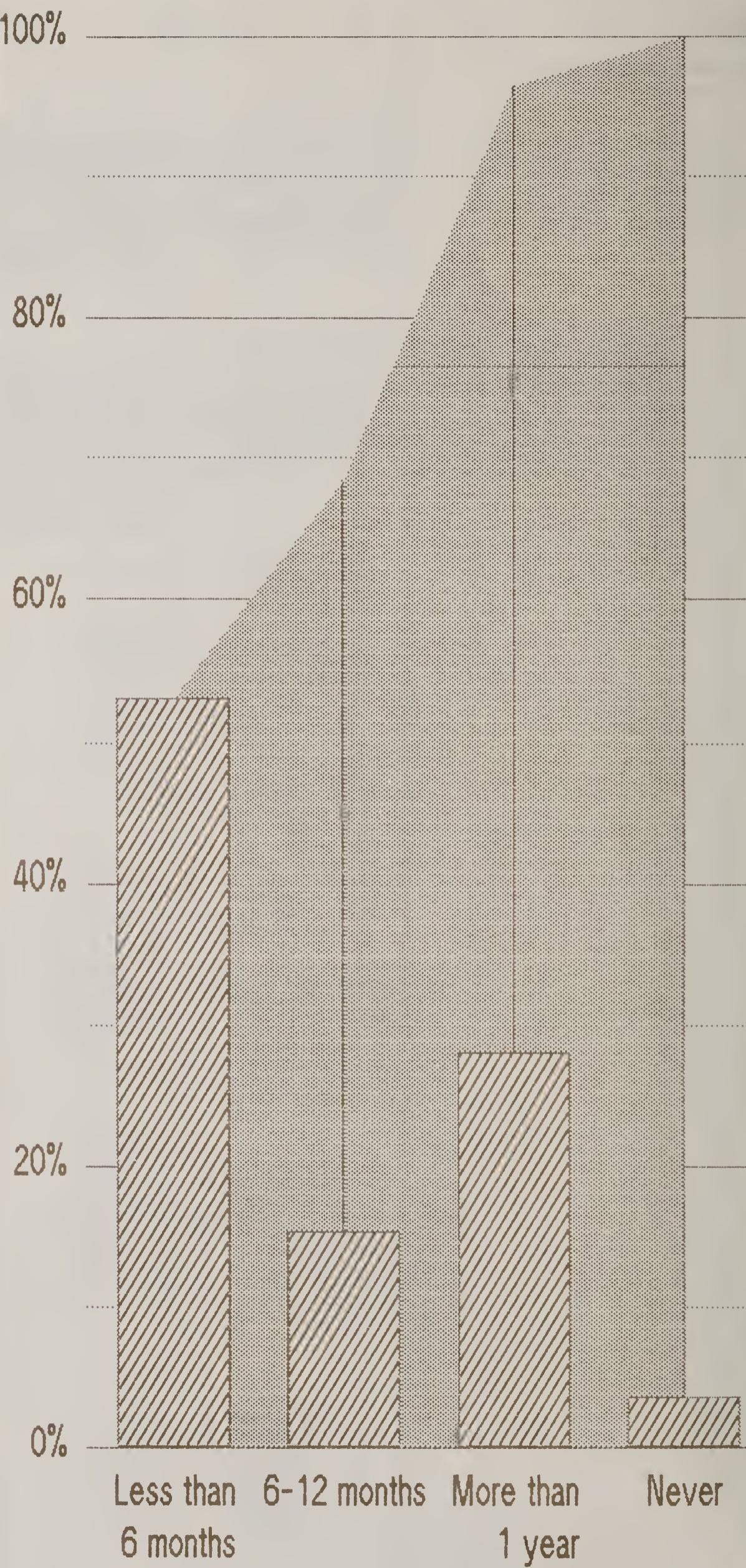
Losing time from work and long office waits were among other reasons for being dissatisfied with health care.



## 6.5

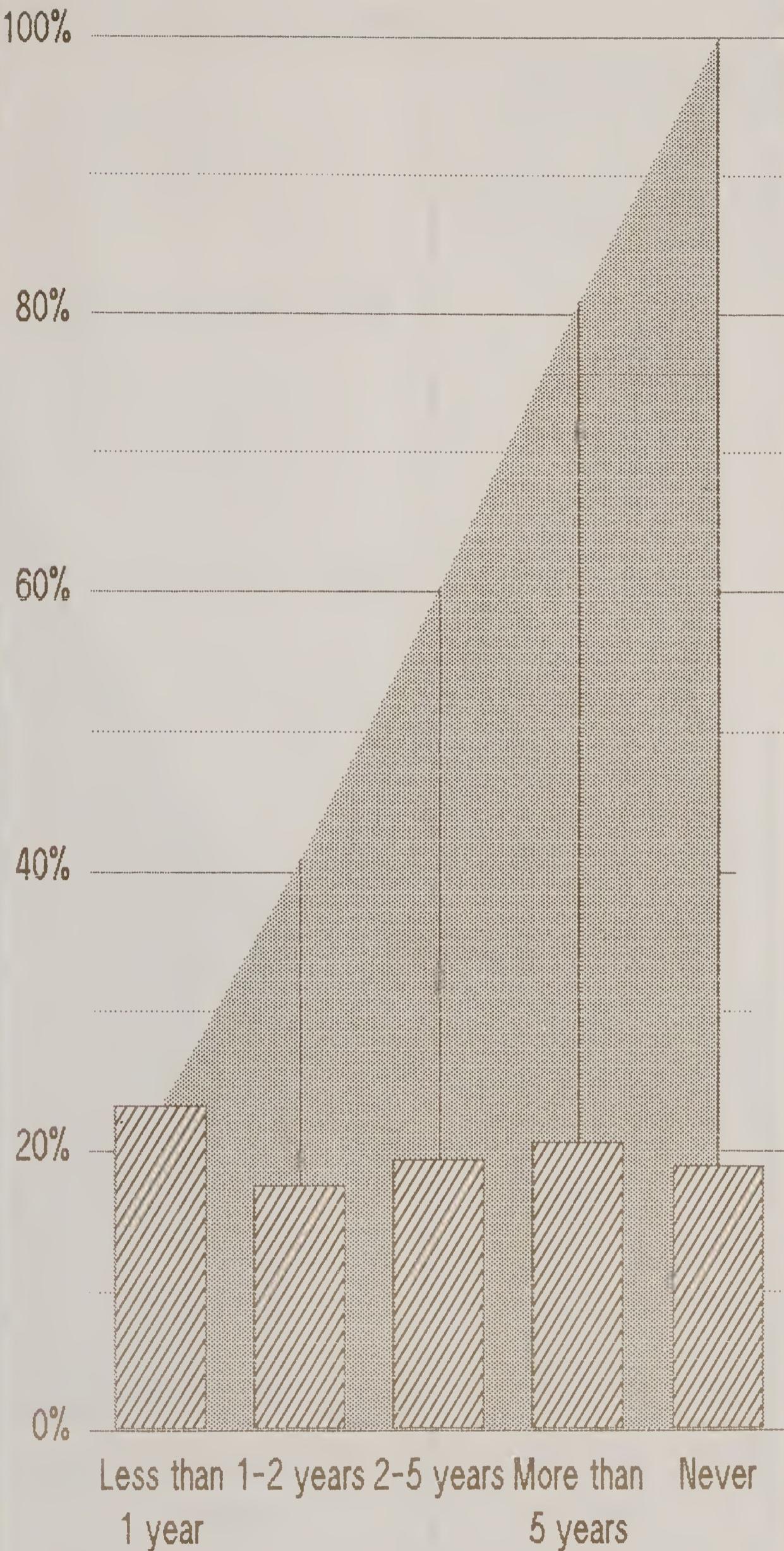
### Preventive Care: Time and Cumulative Time Since Last Blood Pressure Check

Twenty-eight percent of respondents had not had a blood pressure check for over a year, and four percent never had their blood pressure taken.



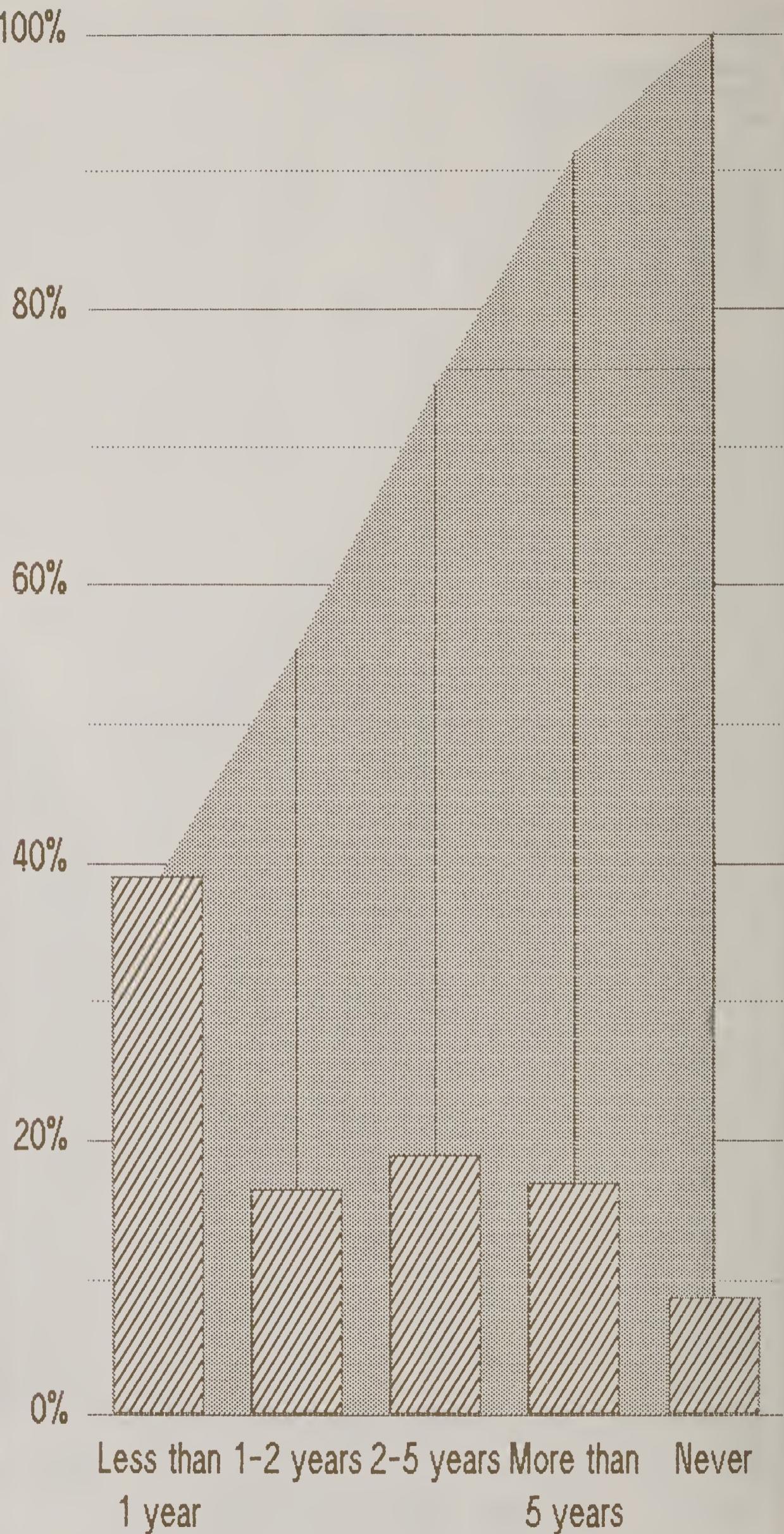
### Preventive Care: Time and Cumulative Time Since Last Physical Examination

Nineteen percent of the respondents have never had a routine physical examination and twenty-one percent had a physical examination five or more years ago.



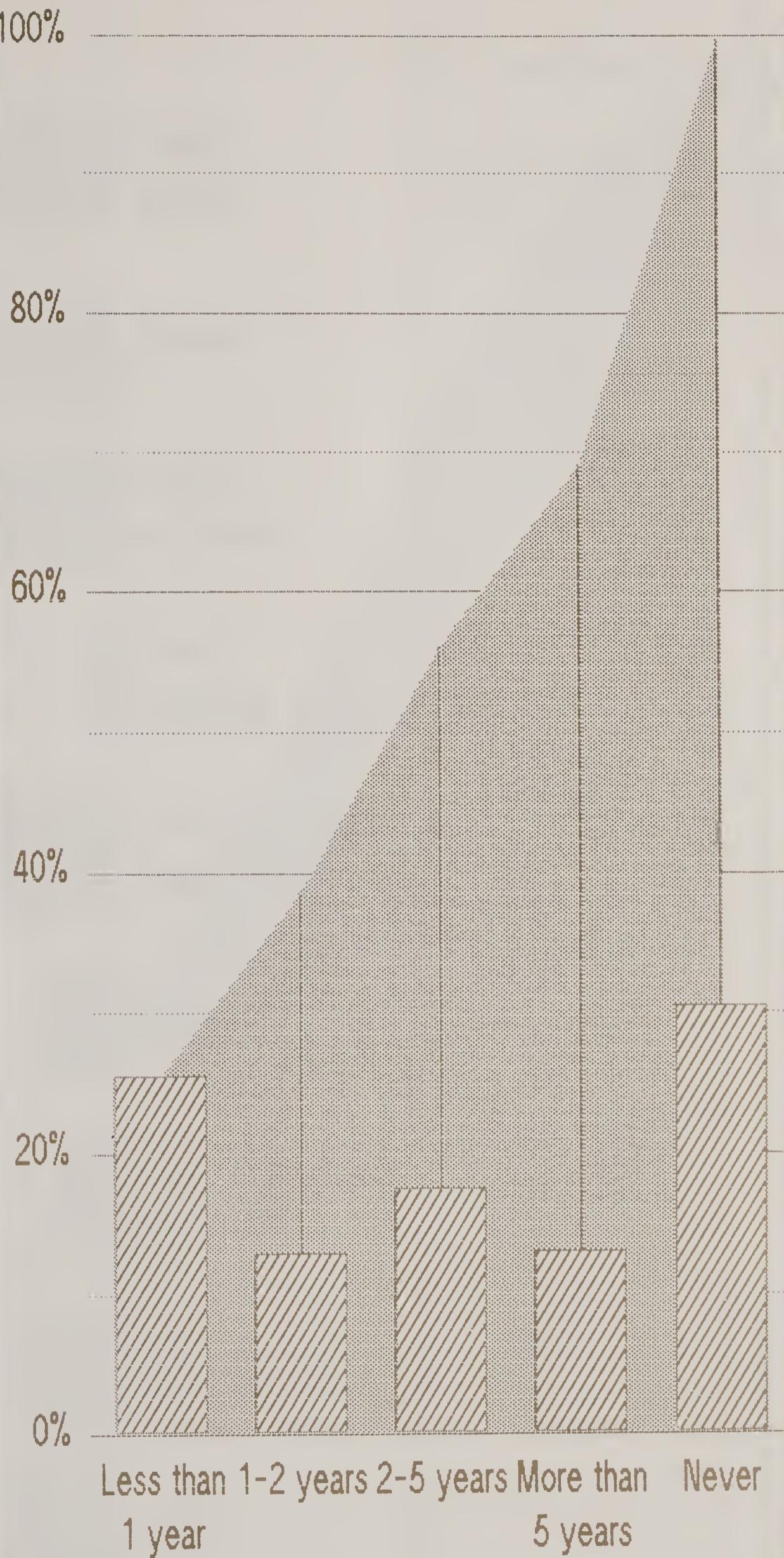
### Preventive Care: Time and Cumulative Time Since Last Dental Examination

Nine percent of the respondents never saw a dentist and seventeen percent last visited a dentist more than five years ago.



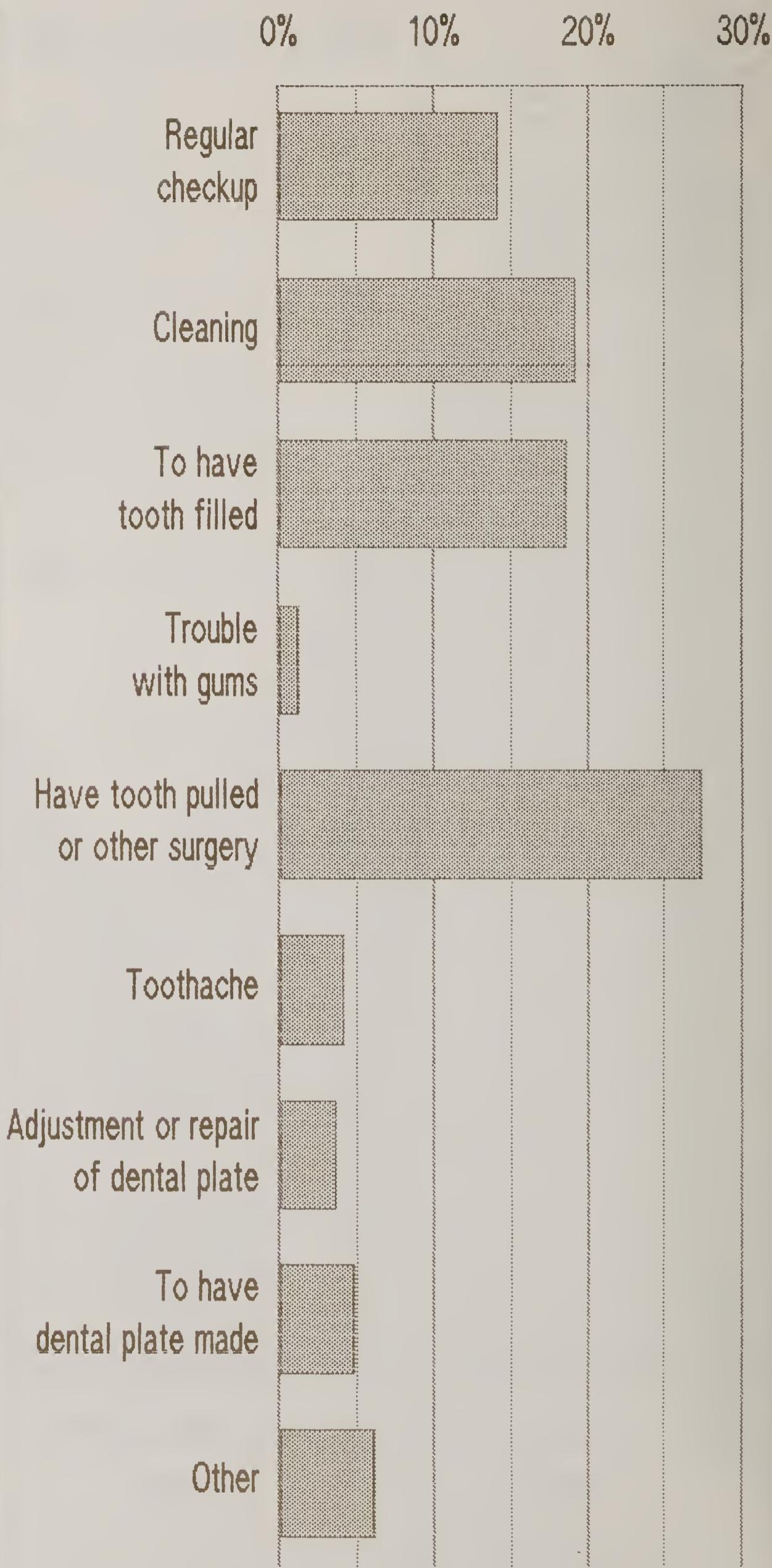
### Preventive Care: Time and Cumulative Time Since Last Cleaning of Teeth

Over thirty percent of the respondents never had their teeth cleaned and fourteen percent have not had their teeth cleaned for more than five years.



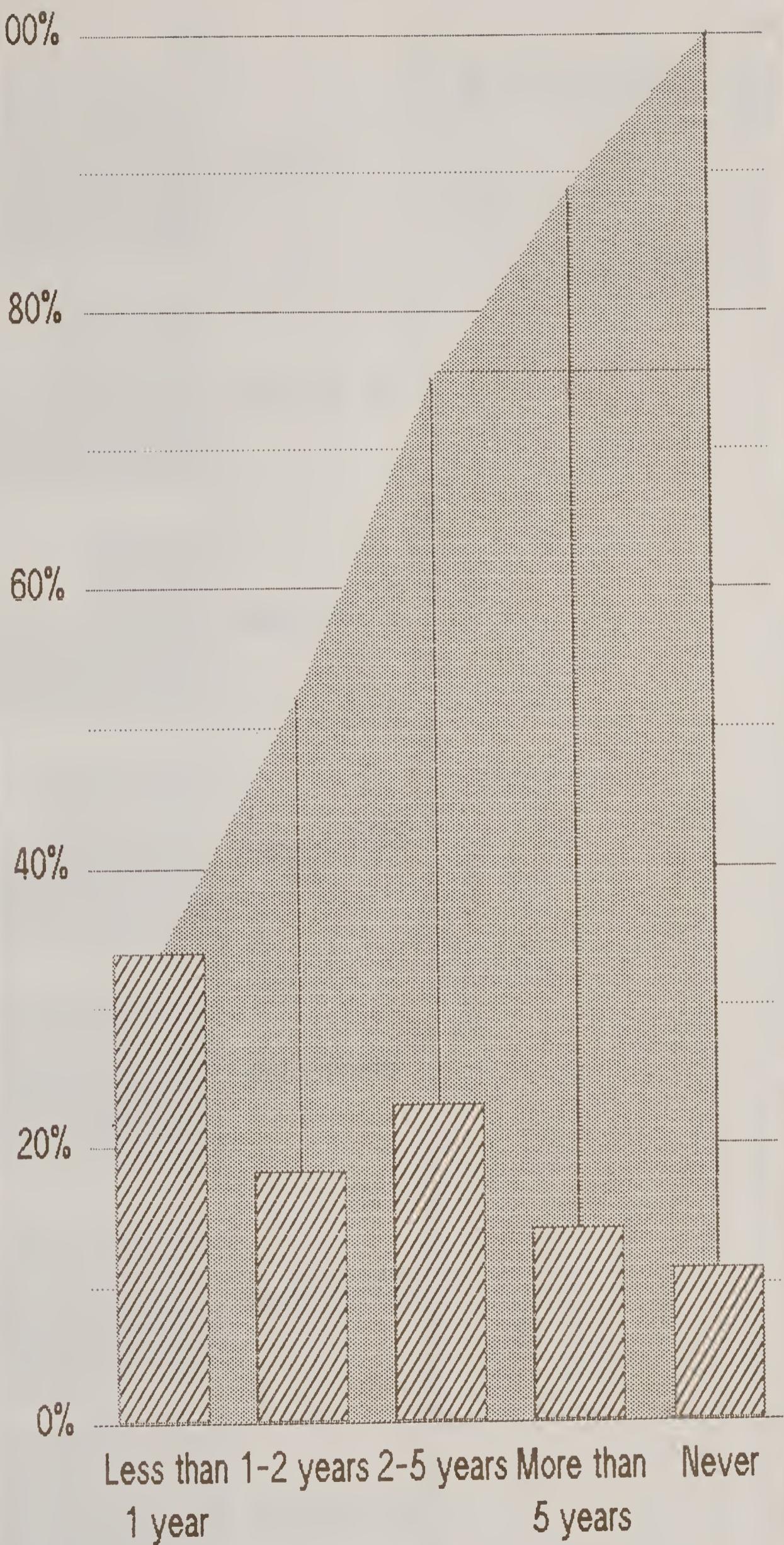
### Reason for Last Visit to Dentist

Although the largest percentage last visited a dentist to have a tooth pulled or other surgery (29%) a large proportion sought routine dental care.



### Preventive Care: Time and Cumulative Time Since Last Vision Screening

Thirty-four percent had their eyes examined less than one year ago, however over 10% never had an eye examination.



**Age-Sex Specific Rates for Stay in Hospital in Last 12 Months.**

Women were about twice as likely as men to have spent at least one night in a hospital during the twelve months prior to the interview.



## **CHAPTER 7**

### **Financial Issues**

Socioeconomic factors had considerable influence upon whether a respondent received medical care when needed. This section indicates that approximately 35% of respondents had no type of insurance coverage. Equally important is the finding that over one half of respondents "not covered by insurance" did not believe they could afford to purchase health insurance.

Several charts in this document reflect the impact of poverty upon the Mexican American family. Nowhere is it demonstrated more poignantly than in this section. A relatively small percentage of respondents were covered by medicaid or other welfare medical benefits.

## Financial Issues

### 7.1

#### Private Health Insurance, Medicaid and Medicare Coverage

Fifty five percent of respondents had private health insurance, however almost 35% had no insurance coverage.

0% 10% 20% 30% 40% 50% 60%

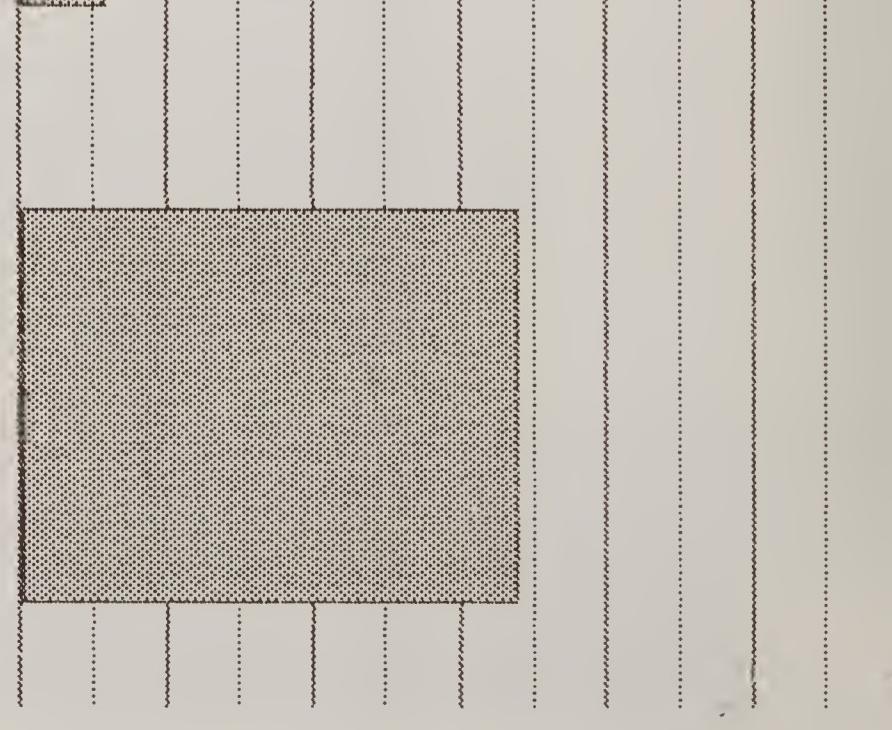
Covered by  
private health  
insurance?



Covered by  
Medicaid?



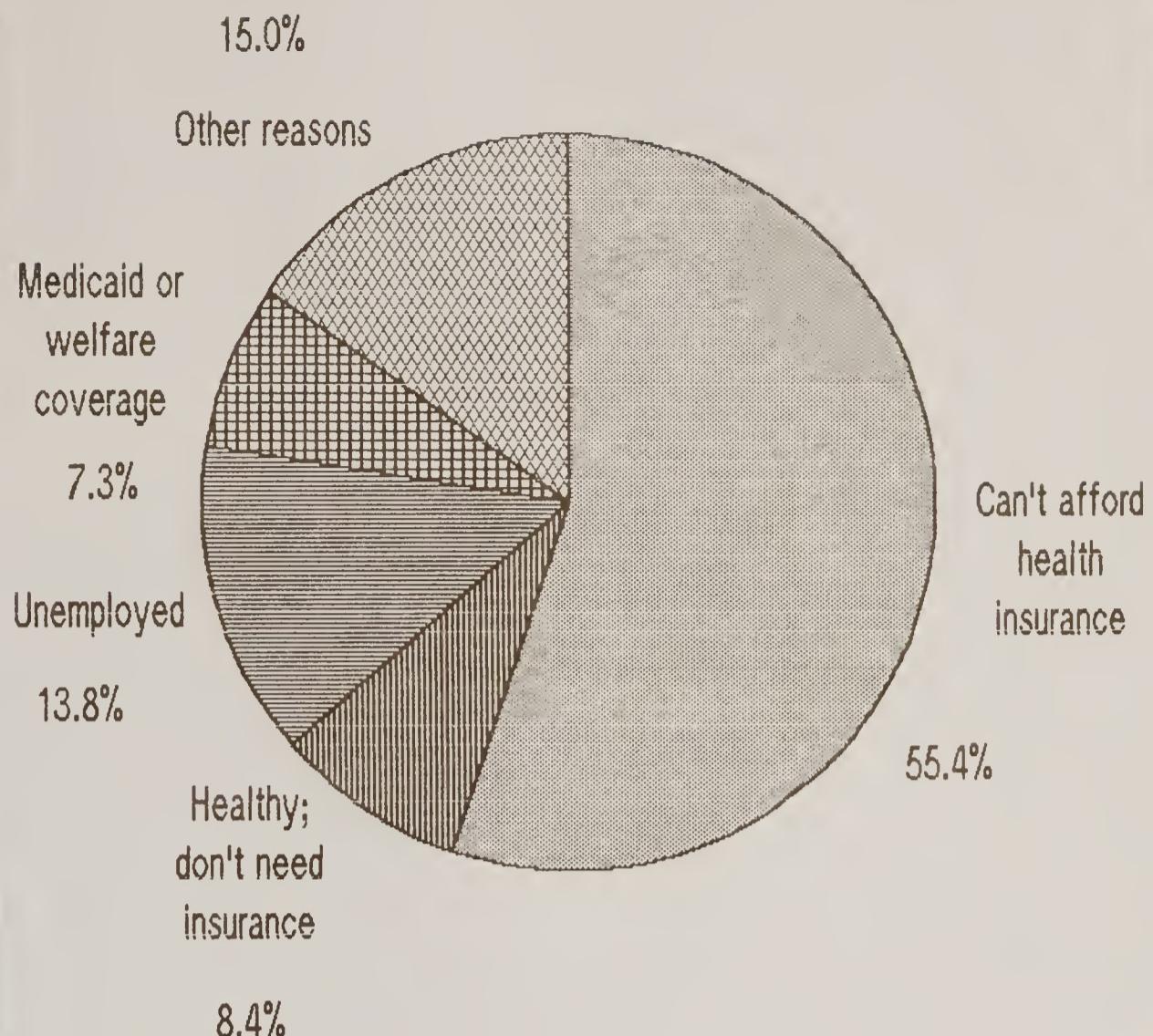
Covered by  
Medicare?



No insurance  
coverage

### Why Respondent is not Covered by Health Insurance

Of those persons without insurance coverage 55% could not afford it and 14% were not employed.



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